Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-024:

Please provide a description of each employee benefit program or plan.

Response:

The following Summary Plan Descriptions ("SPD") are provided as Attachments:

2019 Salaried Pension Plan AB II SPD – Attachment A

2019 CEG Pension Plan AB II SPD – Attachment B

2021 NiSource Health and Welfare Benefits SPD (v.4) for Non-Exempt, Non-Union, Part-Time Employees Hired Before January 1, 2013 [ABP 102] (eff. 1-1-2021) – Attachment C

2021 NiSource Health and Welfare Benefits SPD (v.2) for Non-Exempt, Non-Union, Full-Time Employees Hired Before January 1, 2013 [ABP 101] (eff. 1-1-2021) – Attachment D

2021 NiSource Health and Welfare Benefits SPD (v.3) for Non-Exempt, Non-Union, Part-Time Employees Hired on or After January 1, 2013 [ABP 109] (eff. 1-1-2021) – Attachment E

2021 NiSource Health and Welfare Benefits SPD (v.2) for Non-Exempt, Non-Union, Full-Time Employees Hired on or After January 1, 2013 [ABP 108] (eff. 1-1-21) – Attachment F

2021 NiSource Health and Welfare Benefits SPD (v.3) for Exempt Part-Time Employees Hired Before January 1, 2010 [ABP 105] (eff. 1-1-2021) – Attachment G

2021 NiSource Health and Welfare Benefits SPD (v.2) for Exempt Full-Time Employees Hired Before January 1, 2010 [ABP 104] (eff. 1-1-2021) – Attachment H

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

2021 NiSource Health and Welfare Benefits SPD (v.3) for Exempt Part-Time Employees Hired On or After January 1, 2010 [ABP 107] (eff. 1-1-2021) – Attachment I

2021 NiSource Health and Welfare Benefits SPD (v.2) for Exempt Full-Time Employees Hired On or After January 1, 2010 [ABP 106] (eff. 1-1-2021) – Attachment J

2021 SPD NiSource Health and Welfare Benefits Version ABP 621 – Attachment K

2021 SPD NiSource Health and Welfare Benefits Version ABP 623 – Attachment L

2021 NiSource Health and Welfare Benefits SPD for Retirees [RBP 104] [v.9] – Attachment M

2021 NiSource Health and Welfare Benefits SPD for Retirees [RBP 101] [v.28] – Attachment N

2021 NiSource Health and Welfare Benefits SPD for Retirees [RBP 101Y21] [v.7] – Attachment O

2021 NiSource Health and Welfare Benefits SPD for Retirees [RBP 621) [v.6] CEG Union Full-Time, hired before 1-1-2013 and retired after 1-1-2004 – Attachment P

2021 NiSource Health and Welfare Benefits SPD for Retirees [RBP 622) [v.2) CEG Union Part-Time, hired before 1-1-2013 and retired aft 2-1-2004 – Attachment Q

NiSource Retirement Savings Plan-2020 SPD – Attachment R

NiSource Holiday Policy – Attachment S

NiSource Vacation Policy – Attachment T

NiSource Tuition Reimbursement Plan – Attachment U

Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

NiSource Inc. Adoption Assistance Plan – Attachment V
First Amendment to the NiSource Inc. Adoption Assistance Plan – Attachment W

NiSource Inc. and Northern Indiana
Public Service Company LLC

Summary Plan Description

for the

NiSource Salaried Pension Plan

A Description of Your Retirement Pension Benefits

For Employees in the
AB II Benefit
January 2019

Contents

INTRODUCTION

Retirement can be the most exciting time of your life. Of course, you must work hard and save during your career to achieve the kind of financial security needed to enjoy those years to the fullest. Early on, you will need to ask yourself: "What sources of income will I have for my retirement?" You will likely be relying on (1) your pension benefit from the **NiSource Salaried Pension Plan** (previously known as the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Salaried and Non-Exempt Employees, hereinafter referred to as the "**Plan**"), (2) a retirement benefit from Social Security, (3) your own personal savings, and (4) if applicable, savings under the NiSource Inc. Retirement Savings Plan or any other employer-sponsored retirement plan. Your employer, NiSource Inc.; Northern Indiana Public Service Company LLC (prior to January 1, 2018, Northern Indiana Public Service Company; hereinafter "NIPSCO"); or any affiliate adopting the Plan, offers the Plan for the benefit of employees and their beneficiaries in order to help provide for retirement.

Overview of the Plan

An innovative retirement plan that helps you prepare more effectively for your future, the Plan is a defined benefit pension plan funded entirely by contributions from NiSource Inc. or its affiliates. Its purpose is to provide you with retirement income that is in addition to any other retirement income you have or may be eligible to receive.

As an employee of NiSource Inc., NIPSCO or any affiliate that adopts the Plan for its employees (collectively, the "Company") satisfying the criteria described in the "Eligibility and Enrollment" section, you are eligible for the AB II Benefit of the Plan.

Introduction to the AB II Benefit

You are covered under the **AB II Benefit** of the Plan. The AB II Benefit (formerly the "Account Balance 2011 Option Benefit") is a "cash balance" option that makes it easy to understand your retirement benefit under the Plan. This option is unique because it offers you both a visible and a portable benefit.

Once you become a participant in the Plan, the Company sets up a bookkeeping account in your name. Each year, the Company adds *pay credits* equal to a percentage of your pay to your account. Your account also grows with interest in the form of annual *interest credits* throughout your career. The total of these pay credits and interest credits, plus, if applicable, any "opening balance" reflecting the benefit you earned prior to becoming an AB II Benefit participant make up your account balance. Periodically (in general, annually), you will receive personalized statements showing your current account balance. Because you will always see your account balance, you can easily monitor the growth of your retirement benefit – so your benefit is *visible*. When you retire, you can choose to receive your account balance in one of several payment methods (also explained in more detail later in this Summary). What's more, you are entitled to receive the "vested" portion of your account balance if you leave the Company prior to retirement, so your benefit is also *portable*.

Again, it costs you nothing to participate because the Company makes all contributions necessary to fund your AB II Benefit under the Plan on your behalf.

About this Plan Summary and Plan Administration

This handbook serves as a Summary Plan Description ("SPD" or "Summary") of the Plan, prepared in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. This SPD does not extend or change the Plan in any way.

The NiSource Benefits Committee (the "Committee") serves as business manager and administrator for the Plan (the "Plan Administrator"). The Plan Administrator utilizes the NiSource Human Resource Benefits Department and other specified individuals to carry out a number of administrative tasks for the Plan. See "Administrative Information" found later in this Summary. A trust fund has been established for the purpose of holding funds contributed to the Plan. The trust fund is administered by a trustee (the "Trustee") appointed by the Committee.

While the Committee intends to continue the Plan described in this handbook, the Committee reserves the right to change, modify, or discontinue the Plan and any of its terms at its discretion.

HIGHLIGHTS: AB II BENEFIT

ARE THERE EMPLOYEE CONTRIBUTIONS?	No, all contributions are made by the Company.
ARE THERE COMPANY CONTRIBUTIONS?	Yes; the Company makes contributions to fund your AB II Benefit, which is based on: • Your age; • Your years of service; • Your Eligible Pay, taking into consideration the Social Security Taxable Wage Base; and • The Plan's interest credit rate (currently the annual interest rate on 30-year Treasury Securities as published by the IRS for the month of September immediately preceding the first day of the Plan Year, but no less than 4%)
WHEN AM I VESTED IN MY BENEFIT?	You are fully vested after 3 years of service (if you terminated prior to January 1, 2008, you generally were vested after 5 years of service).
WHAT IS ELIGIBLE PAY FOR PURPOSES OF DETERMINING MY BENEFIT?	In order to calculate your pay credits under the Plan, Eligible Pay includes your base salary and commissions, plus your performance-based pay (such as bonuses or annual incentives) paid in or prior to the month of your termination of service, any salary reduction contributions made for a Company cafeteria or 401(k) plan, any "banked" vacation paid under the NiSource Vacation Policy, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay), and, for certain participants on active duty in the uniformed services, differential wage payments. However, the Plan does <u>not</u> consider certain items to be Eligible Pay. These excluded items include, but are not limited to, overtime, shift differential pay, amounts deferred to a nonqualified plan, and other special forms of pay such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income. In addition, the Plan also excludes from Eligible Pay any unused and accrued vacation paid on or after your termination of service. Note again, Eligible Pay excludes any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance-based pay) when paid in any month following your termination of service.
WHEN IS MY BENEFIT PAID?	Provided you are vested, you can be paid: • When you terminate employment; • When you retire; • When you reach age 70-1/2 and are a terminated employee (payments <u>must</u> begin at this time); or • In the event of your death
HOW CAN I RECEIVE MY BENEFIT?	You may elect to receive your benefit in the form of: • One of several Monthly Annuity Options • A Lump Sum

	• A Rollover

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be a "Pension Eligible Employee" of the Company to actively participate in the Plan. Generally, you are eligible to participate in the AB II Benefit of the Plan (*i.e.*, you are a "Pension Eligible Employee" who is an "AB II Participant") if you are a regular full-time or part-time non-union employee (as classified by the Company) and fall within one of the categories described in the box below. In addition, certain employees employed in the role of Damage Prevention Coordinators with job code NP3459 (or other job title/code that is applicable to this specific position) are eligible to participate in the AB II Benefit of the Plan through April 30, 2019. On and after May 1, 2019, no union employee in the position of Damage Prevention Coordinator will be eligible to participate in the Plan.

A Pension Eligible Employee is either (1) an "exempt employee" (as classified by the Company) whose most recent hire date is before January 1, 2010, or (2) a "non-exempt employee" (as classified by the Company) whose most recent hire date is before January 1, 2013.[1] In other words, if you are an exempt employee hired or rehired on or after January 1, 2010, or a non-exempt employee hired or rehired on or after January 1, 2013, you are not a Pension Eligible Employee and not eligible to participate in the Plan. In addition, you are not eligible to participate in the Plan if you are an intern, an independent contractor, or a leased employee of the Company, or if you are a union employee covered under the NIPSCO Union Pension Plan.

[1] Effective as of July 1, 2015, NiSource Inc. implemented the spin-off of its pipeline and transmission business, comprised of Columbia Pipeline Group, Inc. and its related entities (collectively, the "CPG Entities"), to become independent and unrelated to NiSource Inc. (the "Spin-off Transaction"). The former employees of the Company who transferred to the CPG Entities as a result of the Spin-off Transaction are no longer eligible to participate in the Plan.

More specifically, an AB II Participant is:

- All *exempt* employees (except exempt employees hired or rehired on or after January 1, 2010), including:
  - -- Any exempt employee newly hired or rehired on or after October 1, 2005 but before January 1, 2010;
  - -- Any exempt employee who elected to participate in the AB II Benefit effective January 1, 2006*;
  - -- Any exempt employee on long-term disability as of October 1, 2005 who returned to active employment and who elected to participate in the AB II Benefit or who automatically transitioned to the AB II Benefit effective upon return to employment; and
  - -- All other exempt employees who were participating in the Plan and transitioned to the AB II Benefit effective January 1, 2011 (January 1, 2012 for Disabled exempt employees).
- All *non-exempt* employees (except non-exempt employees hired or rehired on or after January 1, 2013), including:
  - -- Any *non*-exempt employee newly hired or rehired on or after January 1, 2008 but before January 1, 2013; and
  - -- All other *non-exempt* (active and Disabled) employees who were participating in the Plan and transitioned to the AB II Benefit effective January 1, 2013.
- Any employee employed in the position of Damage Prevention Coordinator (Job Code NP3459) from June 1, 2016 through April 30, 2019 who was previously eligible to accrue an AB II Benefit immediately under the Plan prior to employment in the Damage Prevention Coordinator position.
- Certain other persons who are allowed to elect to participate in the AB II Benefit pursuant to terms of the Plan.

***Note:** Each exempt employee who participated in the Final Average Pay Benefit ("FAP Benefit") or the AB I Benefit of the Plan had the opportunity to make an irrevocable Plan choice in December 2005 to stay in his or her current option or switch to the AB II Benefit ("Choice"). If no Choice was made, the employee remained in his or her option under the Plan. The 2005 Choice elections were made and documented in a manner specified by the Plan.

When Your Participation Begins

If you met the eligibility requirements, your participation started on your first day of work with the Company. Note that if you are a full-time employee hired prior to May 1, 2007, your participation in the Plan started upon the completion of your first 12-month period of employment (regardless of the number of hours worked during that period) or, if earlier, as of May 1, 2007.[2] Once you started to participate in the Plan, you continue to participate as long as you are a Pension Eligible Employee of the Company. Note again, that if you terminate employment and are rehired, you are not a Pension Eligible Employee and you are no longer eligible to earn additional benefits under the Plan (though you will continue to earn interest credits on your vested account).

[2] Note that if you were previously an employee of Northern Indiana Fuel and Light Company, Inc. or Kokomo Gas and Fuel Company, and were a participant in the NiSource Subsidiary Pension Plan at that plan's merger into the Plan effective December 31, 2012 (a "Former NIFL Participant" or a "Former Kokomo Participant"), if you are a full-time employee hired prior to May 1, 2007, your participation in the Subsidiary Pension Plan started on the January 1, or July 1 coincident with or next following the completion of your first 12-month period of employment (regardless of the number of hours worked during that period) or, if earlier, May 1, 2007.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer a Pension Eligible Employee (*i.e.*, you terminate employment or your employment status changes to one that is not eligible to participate in the Plan);*
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

* Note that once you are no longer a Pension Eligible Employee, you will remain an inactive Plan participant (continuing to earn interest credits on your vested account) until you take a full distribution of your vested benefit from the Plan.

Service

Your Service with the Company and its predecessors, and also any breaks in your Service, have an effect on your participation in and benefits under the Plan. As explained in the following paragraphs, your "Service" with the Company is used as a component to calculate your benefit under the Plan. Also, the Plan uses Service to determine when you are entitled to (or "vested" in) your benefit under the Plan. Note that if you terminate and return to work, you are no longer a Pension Eligible Employee and will no longer earn Point Service under the Plan upon your return to work. However, you will earn additional Vesting Service as described below.

Point Service

"Point Service" is the number of your years and partial years (*i.e.*, months) of Service as an employee of the Company (or any eligible affiliate of the Company) from the first day of the month in which your employment began through the last day of the year in which your termination of employment, for any reason, occurs. Notwithstanding the foregoing, if you were a FAP Benefit Participant who voluntarily elected to become an AB II Participant, your Point Service for the period prior to your conversion to the AB II Benefit is equal to the amount of credited service you earned prior to your conversion. Point Service is used to determine, in part, the amount of pay credits that are added to your Account. Please see the "How the Plan Works" section later in this Summary for a complete explanation of how your pay credits are calculated.

Vesting Service

"Vesting Service" is the number of your years of Service as an employee of the Company (or any affiliate) from your date of employment through the date of your termination of employment for any reason. To be "vested" means you have a non-forfeitable right to your Plan benefit. You are fully vested in your pension benefit after completing three years of Vesting Service with the Company and/or an affiliate. Note that if you terminated prior to January 1, 2008, you generally had to complete five years of Vesting Service before becoming fully vested in your benefit (unless you terminated at a time when an even higher vesting requirement applied, in which case the terms of the Plan in effect at your termination will control).

Special rules may apply if you experience a break in service, become Disabled (as defined in "If You Become Disabled" found later in this Summary) or if you were previously a leased employee of the Company or an affiliate.

Break in Service

A break in employment (called a "Break in Service") may affect how you are credited with Vesting Service under the Plan. With respect to Vesting Service, a Break in Service occurs if you terminate employment with the Company and are not employed for a period of 12 consecutive months. If you incur a Break in Service, the effect on your Vesting Service will depend on the following: (1) the length of your Break in Service and (2) whether you were vested in your pension benefit prior to the Break in Service.

Note again that if you terminate and return to work, you are no longer a Pension Eligible Employee and will no longer earn Point Service under the Plan upon your return to work. Accordingly, the following Break in Service provisions only apply for purposes of determining your Vesting Service. If you experience a transfer of employment within the Company or from/to an affiliate of the Company, see the section entitled "Changes in Employment Status" later in this Summary for an explanation of the impact on your benefit and Service crediting under the Plan.

Break in Service Less Than 1 Year

If you terminate employment and are reemployed by the Company within 12 consecutive months, you are not considered to have a Break in Service. In this case, your hours of Service earned prior to your termination of employment will be reinstated and the Plan will consider your period of absence as part of your Vesting Service under the Plan.

Break in Service of 1 to 5 Years

If you terminate employment and your Break in Service lasts more than 1 year but less than 5 years, the Vesting Service you earned before your termination will be added to the Vesting Service you earn after you return to work for vesting purposes under the Plan. If you are re-employed, the period of your absence will not count as part of your Vesting Service for any purpose.

Break in Service More Than 5 Years

If you are not vested in your pension benefit prior to your Break in Service, and your Break in Service lasts for 5 or more years, you will lose credit for all of your prior Vesting Service and will forfeit the unvested pension benefit accrued prior to your Break in Service.

If you are vested when you terminate employment and you are later re-employed after a Break in Service of 5 or more years, you will remain vested upon your return to work.

Effect of Leaves on Break in Service

If you are on an "Authorized Leave of Absence" as discussed below, the Break in Service rules do not apply to the extent you continue to earn Service during the authorized leave. If the authorized leave provisions don't apply and you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement, then different rules apply when determining if a Break in Service has occurred. In general, if you are absent from work for one of the foregoing reasons beyond the first anniversary of the first date of your absence, you will not be considered to have a severance from Service until the second anniversary of the first date of your absence. In addition, you will not have a Break in Service if you are on an Authorized Leave of Absence pursuant to the Family and Medical Leave Act, or if you are absent from employment due to service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")) and if you return to work at the end of your Authorized Leave of Absence.

Other Circumstances Impacting Service

Authorized Leaves of Absence. If you are on a leave of absence that is approved by the Company in accordance with its procedures and the Plan (an "Authorized Leave of Absence"), you will continue to earn Vesting Service and Point Service while the authorized leave continues for a period of up to 12 months. Service crediting will cease as of the expiration of the 12 month period or, if earlier, the date the Authorized Leave of Absence ends (unless you return to work at that time).

Disability. Vesting Service and Point Service are also impacted if you become Disabled (as defined in the Plan). For information on how the Plan defines "Disability", and to learn how a Disability affects your benefit and the Service you earn under the Plan, see "If You Become Disabled" found later in this Summary.

HOW THE PLAN WORKS

As explained at the beginning of this Summary, the AB II Benefit of the Plan is a "cash balance" pension plan. A cash balance pension plan is just like other pension plans in that it can provide you with a guaranteed monthly pension benefit for life after you retire. A cash balance plan is different from other pension plans in how it defines what your benefit will be. "Traditional" pension plans use a formula, often based on your years of service and average pay leading up to retirement, to define how much your monthly pension will be. Under this kind of plan, it is hard to know the value of what you will ultimately receive when you retire until you near or reach retirement.

A cash balance plan is designed to help you better understand the value of your benefit. Instead of using a formula to define your monthly retirement pension, a cash balance plan provides an accounting of the value of your benefit (the value of your **AB II Benefit**, also known as your "**Account**"). Your benefit is based on the value of the Account kept for you. As you work, credits are made to your Account. When you retire, you will receive the value of your Account in one of the payment forms available under the Plan (these are explained in detail later in this Summary).

Also, while most traditional pension plans only let you receive your benefit as a monthly payment (*i.e.*, an annuity), the AB II Benefit gives you the option of receiving a single lump-sum cash payment. In addition, while many traditional defined benefit plans provide your benefit as a monthly annuity that ends at your death or your surviving spouse's death,[3] with the AB II Benefit you can name any beneficiary to receive your benefit in the event of your death, such as a child or unrelated beneficiary, provided the consent requirements explained later in this Summary are satisfied.

Your Account

The Company sets up an account in your name (your "Account") once you become a participant in the Plan. Your Account is a bookkeeping account maintained for plan administration to keep track of your pay credits and interest credits and any distributions made to you from the Plan. *The dollar amount in your Account generally tells you the current cash value of the benefits payable to you at your retirement (subject also to any Protected Benefit calculation described later in this Summary)*.

Opening Balance

Transition from the FAP Benefit to the AB II Benefit. If you participated in the FAP Benefit under the Plan before becoming an AB II Benefit participant, your accrued FAP Benefit was converted to a lump sum "Opening Balance" and credited to your Account as of the date you converted to the AB II Benefit (your "Conversion Date"). The Opening Balance is calculated by following these steps:

1. The value of your accrued FAP Benefit is determined as of your Conversion Date;

2. If your projected credited service to the first day of the month following the date you would attain age 60 (or actual credited service if over age 60) equals or exceeds 25 years, the Opening Balance reflects an unreduced benefit;

3. If your projected credited service to the first day of the month following the date you would attain age 60 (or actual credited service if over age 60) does not equal or exceed 25 years, the value of the accrued benefit is reduced by an early retirement reduction factor (0.5% per month) for each month between the first day of the month following the date you attain age 65 and the later of (a) the Conversion Date or (b) the first day of the month following the date on which you would attain age 60; and

[3] The term "spouse" shall mean any individual who is lawfully married to a Plan participant under any state law, including individuals married to participants of the same sex.

4. The present value of the lump sum benefit is calculated using standard mortality and interest rate assumptions as provided in the Plan.

Transition from the AB I Benefit to the AB II Benefit. If you participated in the AB I Benefit under the Plan before becoming an AB II Benefit participant, your Opening Balance simply equals the balance of your AB I Benefit account as of your Conversion Date, including any Pay Credits or Interest Credits (described below) earned up to that date.

Determining Your Eligible Pay

As described below, your Pay Credits are based upon your **Eligible Pay**, which refers to the compensation on which your Pay Credits are calculated. Your Eligible Pay generally equals:

- Your annual base pay received from the Company, including
- Salary reduction contributions made for you under a cafeteria plan or a 401(k) plan, plus
- Commissions, if you are compensated in whole or in part on a commission basis, plus
- Performance-based pay such as bonuses or annual incentive payments (provided such amounts are paid in or prior to the month of your termination of service), plus
- Any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay)[4], plus
- Any amounts attributable to "banked" vacation and paid to you under the NiSource Vacation Policy, plus
- For certain participants on leave as a result of active duty in the uniformed services, differential wage payments.

However, Eligible Pay does <u>not</u> include all types of compensation you might receive from the Company. Specifically, items <u>excluded</u> from Eligible Pay include, but are not limited to the following:

- Overtime pay,
- Shift differential pay,
- Amounts deferred to a nonqualified plan,
- Any unused and accrued vacation paid on or after termination of service,
- Any portion of performance-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance-based pay) that is paid in any month following your termination of service, and
- Other special forms of compensation, such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

In general, Eligible Pay shall be determined on a monthly basis. If you are a full-time employee paid on a monthly, semi-monthly, biweekly, or weekly basis, your monthly Eligible Pay equals one-twelfth of your annual base rate of pay last in effect for the month, plus pay inclusions described above such as actual commissions paid in the month. If you are a part-time employee, your monthly Eligible Pay equals the sum of your actual Eligible Pay, plus pay inclusions described above (such as commissions) paid to you for each pay period during the month. For purposes of determining your Pay Credits (described below), Eligible Pay means the sum of the monthly Eligible Pay for each month during the Plan Year in which you are an AB II Participant, including actual bonuses received by the Employee while actively employed in the month.

The IRS imposes a limit on the amount of Eligible Pay that may be taken into account by the Plan. As a result, Eligible Pay above $275,000 for 2018 (as adjusted annually by the IRS for cost-of-living increases) does not count for purposes of determining Pay Credits under the Plan.

[4] Included effective September 1, 2009.

Impact of Disability Leave, an Authorized Leave of Absence, or Other Absence on Your Eligible Pay: If you are participating in the Plan, and you are on a leave due to Disability (as defined in the Plan and as further described in "If You Become Disabled" found later in this Summary) or on an Authorized Leave of Absence or other absence approved by the Company, you will be deemed to receive Eligible Pay for purposes of calculating your Plan benefit during your period of leave. However, similar to service crediting described earlier, if on an Authorized Leave of Absence or other approved (non-Disability) leave, you will only receive Eligible Pay crediting for up to 12 months. Your Eligible Pay for each month during the period of pay crediting for Disability, Authorized Leave of Absence, or other approved absence (as applicable) generally shall equal one-twelfth of your annual base rate of pay last in effect for the month in which the employment absence occurred. In addition, solely for the month in which the Disability, Authorized Leave of Absence, or other approved absence begins, your Eligible Pay will include any other items that are generally included in Eligible Pay that you receive in the month the absence begins (but such amounts will not otherwise affect the rate of Eligible Compensation crediting during the absence). For more specific information on how Eligible Pay is calculated during any of the above-described absences from employment, please contact the NiSource Human Resource Benefits Department.

Pay Credits

The Plan provides for two types of Pay Credits: Basic Pay Credits and Excess Pay Credits. You are eligible to receive Basic Pay Credits and, if applicable, Excess Pay Credits effective generally as of the date you become an AB II Participant and up until the time you terminate service or otherwise stop accruing a benefit under the AB II Benefit provisions of the Plan.

The Company allocates Basic Pay Credits to your Account as of December 31 of each year. These Basic Pay Credits are equal to a percentage of your annual Eligible Pay. The total age and years of Point Service you accumulate each year, as measured on December 31, determines the annual Basic Pay Credit percentage. If you leave the Company mid-year, you will receive prorated Basic Pay Credits through your termination date.

The Company also allocates Excess Pay Credits as of December 31 of each year to qualifying participants' Accounts. Excess Pay Credits are available if you earn more than one-half of the Social Security Wage Base for that year. If you qualify, the Excess Pay Credit is 1% of your Eligible Pay that exceeds one-half of the Social Security Wage Base.

The table below shows how Basic Pay Credits and Excess Pay Credits are calculated:

AB II Pay Credits			
If your age plus years of Point Service at the end of the year total…	Less than 50	50-69	70+
Your Basic Pay Credit for that year will be equal to this percentage of your Eligible Pay…	4 %	5 %	6 %
Your Excess Pay Credit will be equal to an additional percentage of your Eligible Pay over one-half of the Social Security Wage Base* in effect that year…	1 %		

*The Social Security Wage Base (SSWB) is the maximum amount of eligible pay on which you and the Company pay Social Security (or OASDI) taxes each year. For 2018, the SSWB is $128,400. Because you do not pay Social Security taxes on eligible pay in excess of the SSWB, you also do not earn Social Security benefits on eligible pay in excess of the SSWB. To help compensate affected employees, the AB II Benefit provides additional credit on pay over one-half the SSWB, which is $64,200 in 2018 ($128,400 divided by two).

Example

Assume that on December 31, 2018, a participant has attained age 40 years and 6 months, and has earned Point Service of 8 years and 10 months. Because the participant will have a total age plus Point Service of 49 years and 4 months, he or she will be eligible for a Basic Pay Credit of 4%. Let's assume the participant earns $40,000 for the year. The participant would receive a Basic Pay Credit to his Account of $1,600 for 2018 (4% of $40,000). The participant would not be eligible for the Excess Pay Credit because his Eligible Pay is not in excess of one-half of

the SSWB for the year. However, if the same participant's Eligible Pay were $65,000 for 2018, he would receive a Basic Pay Credit of $2,600 (4% of $65,000), plus an Excess Pay Credit of $8.00 (1% of $800, which is the excess of Eligible Pay over one-half of the SSWB).

Interest Credits

Interest is credited to your Account each Plan Year effective as of December 31 up until the time you commence retirement benefits. Interest Credits are based on the 30-year Treasury Securities Rate as published by the IRS for September of the preceding year (but not less than 4%) and are applied to your Account based on the value of your Account as of the last day of the prior Plan Year.

Your Account will continue to receive Interest Credits until you commence your retirement benefit payments under the Plan, regardless of whether you have stopped working for the Company as a Pension Eligible Employee. However, if you terminate employment with the Company before you are vested in your benefit, you will not receive Interest Credits after your termination. If you are subsequently reemployed, you will receive Interest Credits effective as of the date of your reemployment. In the year you begin receiving benefits, you will receive prorated Interest Credits for the portion of the year before the benefit starts. If you become a participant in the Plan mid-year, you will receive prorated Interest Credits from the date your participation began.

Example

Assume that on January 1, 2018, your Account is $50,000, and that the Interest Credit rate for the Plan Year is 4% (*i.e.*, the greater of the 30-year Treasury Securities rate as published by the IRS for September 2017 or 4%). On December 31, 2018, your Account would receive an Interest Credit of $2,000 (or $50,000 × 4%).

Summing it Up: How Your Account Grows

Altogether, taking into account the Pay Credit (both Basic and Excess) and Interest Credit components, your Account is thus the sum of:

- Y*our Opening Balance*, if any, under the Plan as of the beginning of the year; plus
- *Pay Credits* allocated to your Account as an annual percentage of eligible pay based on age plus Point Service as outlined in the table above; plus
- *Interest Credits* allocated to your Account based on the annual interest rate on 30-year Treasury Securities as published by the IRS for the September immediately preceding the first day of the Plan Year (but no less than 4%).

Example

With the addition of both Interest and Pay Credits each year, you can see your Account balance grow. Here is an example of how your Account can grow in one year, using the assumptions set forth below.

First, calculate the Basic and Excess Pay Credit:

If you are 49 years old, have eligible earnings of $65,000 and have completed 17 years of Point Service at the end of 2018, your 2018 Pay Credit would be calculated as follows:

Basic Pay Credit

Your 2018 Eligible Pay	$65,000
Your Basic Pay Credit % (49 + 17 = 66 points = 5%)	x 5%
Your Basic Pay Credit amount on December 31, 2018	***$3,250***

Excess Pay Credit

Your 2018 Eligible Pay over ½ SSWB ($65,000 – $64,200)	$800
Your Excess Pay Credit %	x 1%
Your Excess Pay Credit amount on December 31, 2018	***$8.00***

Your total Pay Credit on December 31, 2018 is the sum of $3,250 + $8.00 or a total of $3,258.00 for the year.

Second, add the Interest Credit:

If the interest rate is at 4% for the Plan Year, your Interest Credit would be 4% of your Account balance as of the beginning of the Plan Year. Assuming your Account balance as of January 1, 2018 was $50,000, then you received an Interest Credit effective as of December 31, 2018 equal to $2,000.

Finally, total the Pay Credits and Interest Credit, and add to the Account balance at the beginning of the year:

January 1 Account Balance (includes your "Opening Balance," if any)	$50,000
	+
December 31 Interest Credit (4%)	$2,000
	+
December 31 Basic Pay Credit (5%)	$3,250
	+
December 31 Excess Pay Credit (1%)	$8.00
December 31 Account Balance	***$55,258.00***

Remember, how your Account grows over time depends on the actual Eligible Pay you receive and the Interest Credits allocated to your Account. In other words, items impacting Eligible Pay, such as base pay increases and performance-based pay (*e.g.*, bonuses or annual incentive payments paid before employment termination) will impact how your Account will grow.

Monitoring the Growth of Your Account

To help you track the growth of your Account, you will receive personalized statements (generally on an annual basis) that will keep you up-to-date on your Account activity. These statements show your:

- Account;
- Pay Credits since the last statement;
- Any applicable Interest Credits since the last statement.

You can also obtain information on the value of your Account any time by contacting the Benefits Center at **1-888-640-3320** or by visiting the Web site **www.mysourceforhr.com**.

Benefits From Your Account

Although your Account is communicated to you as a lump-sum amount, when you leave the Company and commence benefits, as previously mentioned, your Account can provide a monthly annuity based on prevailing interest rates at the time you commence benefits. See the "Payment Options Under the Plan" section later in this Summary for details on how you may receive your benefit, and see the "Designation of Beneficiary" section for

details on how you may designate your spouse or another individual to receive your benefit in the event of your death.

For example, if your Account balance on the date you commence benefits is $200,000 and the annuity factor for your age (to convert your Account to an annual benefit) at that time is 14, you would receive either a lump sum of $200,000 (minus applicable withholding taxes) or a monthly benefit for life of approximately $1,190, as follows:

Calculating Annuity Example	
Account Balance:	$200,000
Annuity Factor:	÷ 14
Annual Benefit:	$ 14,285
	÷ 12
Monthly Benefit:	$ 1,190

Protected Benefit

In addition to your Account, the Plan may also consider a "Protected Benefit" in calculating your retirement benefit.

Former FAP Benefit Participants

If you previously participated in the FAP Benefit of the Plan, your Plan benefit under the AB II Benefit is guaranteed to be no less than the sum of (1) the lump-sum actuarial equivalent of your accrued benefit under the FAP Benefit (which does not include any supplemental benefit) using eligible pay and Service through your Conversion Date (your "**Protected Benefit**"), plus (2) your Pay Credits (and Interest Credits earned on those Pay Credits) under the AB II Benefit from your Conversion Date (*i.e.*, the date of conversion to your AB II Benefit) through your termination of employment.[5]

If you are eligible for this Protected Benefit, the Protected Benefit component of your benefit generally will be reduced if you elect to receive it prior to your "Normal Retirement Date" to reflect early commencement of payment. Because your Protected Benefit is derived from a traditional pension plan formula, you would generally not be able to receive your benefit until you retired. As noted earlier though, one benefit of the Plan's cash balance status is that you may receive your benefits anytime after your termination of employment. However, for purposes of valuing *only* the Protected Benefit portion of your Plan benefit, the Plan will consider whether you begin to receive benefits before your "Normal Retirement Date." The following subsections describe how the calculation of your Protected Benefit may be affected by when you choose to receive your benefit.

As a reminder, your AB II Benefit is calculated as described in the preceding portions of the "How the Plan Works" section. The following subsections apply *only* for any Protected Benefit portion of your Plan benefit and *do not* apply to the calculation of your AB II Benefit. For additional information regarding your FAP Benefit (if applicable), which is the basis of your Protected Benefit, please refer to the Summary Plan Description that you received for your FAP Benefit.

Normal Retirement

If you retire on or after your "Normal Retirement Date," your Protected Benefit will be not be impacted. Your "**Normal Retirement Date**" is the first day of the month following the later of (1) the date you reach age 65 (your

[5] Note that if you were (1) previously an employee of Northern Indiana Fuel and Light Company, Inc. or Kokomo Gas and Fuel Company, (2) employed by either of those entities on January 1, 1994, and (3) a participant in the NiSource Subsidiary Pension Plan at that plan's merger into the Plan effective December 31, 2012 (a "Former NIFL Participant" or a "Former Kokomo Participant"), your Protected Benefit may include a component from the prior plans of the respective prior entity. See the Plan Administrator for more information on such benefits and distributions options associated with such benefits.

"**Normal Retirement Age**"[6], as defined under the Plan); or (2) the fifth anniversary of the date you began participation in the Plan. If you retire on or after your Normal Retirement Date, the amount of your Protected Benefit will be based on the full amount of your Protected Benefit up to your Conversion Date (provided that your Protected Benefit will be no less than $350 per month if you terminated on or after June 1, 1990 or $250 per month if you terminated prior to June 1, 1990) Your benefit will not be reduced for early commencement of payment.

Note that if you were previously an employee of Northern Indiana Fuel and Light Company, Inc. or Kokomo Gas and Fuel Company and a participant in the NiSource Subsidiary Pension Plan at that plan's merger into the Plan effective December 31, 2012 (a "Former NIFL Participant" or a "Former Kokomo Participant"), the minimum monthly benefit of $350 or $250 described above in this subsection does not apply to you.

Early Retirement

If you retire on or after reaching your "Early Retirement Age" (*i.e.*, on your "Early Retirement Date") but before your Normal Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. Your "**Early Retirement Date**" is the first day of the month following your employment termination on or after the date that you have both attained age 55 (or older) and completed at least 10 years of Service. If you reach your Early Retirement Date, you may elect to retire and receive your benefits immediately or defer the commencement of your benefits until you reach your Normal Retirement Date.

If you retire with less than 25 years of Service for benefit accrual purposes under the Plan and elect to receive benefits at or after your Early Retirement Date, the amount of your Protected Benefit would be reduced by 6% for each of the first 5 years that your benefit commencement precedes your Normal Retirement Date, and 4% for each of the next five years that your benefit commencement precedes your Normal Retirement Date (provided that your Protected Benefit will not be reduced below $350 per month if you have 20 or more years of Service for benefit accrual purposes or below $250 per month if you have less than 20 years).

If you retire with 25 or more years of Service for benefit accrual purposes and elect to receive your benefits at or after your Early Retirement Date, the amount of your Protected Benefit would be reduced as follows (provided that your Protected Benefit will not be reduced below $350 per month):

Age at Retirement	Percent of Reduction	Age at Retirement	Percent of Reduction
64 to 65	0	59 to 60	6
63 to 64	0	58 to 59	10
62 to 63	0	57 to 58	14
61 to 62	0	56 to 57	18
60 to 61	0	55 to 56	22

If you defer the receipt of your benefits until your Normal Retirement Date, the amount of your Protected Benefit will not be reduced.

Note that if you are a Former NIFL Participant or a Former Kokomo Participant, the Early Retirement reduction that would apply to your Protected Benefit if you have less than 25 years of Service would be the same as described above. However, if you have 25 or more years of Service, the reductions in the chart above do not apply. Instead, your Protected Benefit would be reduced by 0.5% for each month or partial month that you commence benefits prior to age 60. In addition, also note that the $350 or $250 minimum monthly benefit amounts described above in this subsection do not apply to you.

Distribution Prior to Early Retirement

If you terminate prior to your Early Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced actuarially to reflect the early commencement of your benefit (provided that your Protected

[6] Note that reaching your "Normal Retirement Age" as defined under the Plan does not necessarily mean you are entitled to a retirement benefit from Social Security. For more information on when you may be eligible to receive benefits from Social Security, see "A Note on Social Security Benefits" later in this Summary.

Benefit will not be less than $25 times your years of Service up to 10 years). This actuarial reduction will be calculated using the interest rate and mortality factors specified in the Plan.

Note that if you are a Former NIFL Participant or a Former Kokomo Participant, the minimum benefit of $25 multiplied by years of Service up to 10 years does not apply to you.

Former AB I Benefit Participants

As indicated earlier under the "Your Account" portion of this Summary, if you previously participated in the AB I Benefit under the Plan, your Plan benefit under the AB II Benefit will be no less than the sum of (1) the balance of your AB I Benefit account as of your Conversion Date, plus (2) your Pay Credits (and Interest Credits earned on those Pay Credits) under the AB II Benefit from your Conversion Date. If you participated in the FAP Benefit prior to transitioning to the AB I Benefit, then your Plan benefit under the AB II Benefit shall also be no less than your FAP Benefit when it was converted to the AB I Benefit.

Calculating Your Benefit

The calculation of your benefit under the Plan depends on how and when you wish to receive your benefit. Of course, if you terminate employment and elect to begin receiving your Plan benefit right away, your Account will have a smaller balance than if you had worked longer or waited to receive your benefits until a later date. Remember, you stop accruing Pay Credits when you terminate employment, and you no longer earn Interest Credits once you begin receiving your benefit. In addition, if you begin payment of your benefits prior to your Normal Retirement Age, your Protected Benefit (if applicable) would be reduced as explained above.

Your total benefit under the Plan is your Accrued Benefit. Your "**Accrued Benefit**" is the value of your benefit under the Plan as of any date before you reach your Normal Retirement Date. Your Accrued Benefit is generally the current value of your entire Account. However, if you have a Protected Benefit as described above, your Accrued Benefit is generally equal to the greater of:

1. Your entire Account (reflecting all Pay Credits, Interest Credits and any Opening Balance); **or**
2. Your benefit you earned under the FAP Benefit as of your Conversion Date (*i.e.*, your Protected Benefit, which does not include any supplemental benefit), PLUS the portion of your AB II Benefit Account reflecting Pay Credits and Interest Credits earned from conversion to the AB II Benefit until termination of service (with Interest Credits continuing until commencement of benefits). In other words, the calculation under this subparagraph 2 considers your Protected Benefit plus your Account but without consideration of any Opening Balance (or interest thereon) (*i.e.*, under this calculation, your prior FAP Benefit is considered as your Protected Benefit rather than as your Opening Balance).

If you are interested in finding out your benefit under the Plan, you may have your benefit calculated by calling the Benefits Center at 1-888-640-3320 or visiting the Web site **www.mysourceforhr.com**.

Funding: Who Pays For Your Benefit

The Plan is funded with contributions made by the Company. On an annual basis, the Plan Administrator actuarially determines the amount that the Company must contribute in order to fund the pension benefits for you and your fellow co-workers that participate in the Plan.

Vesting: When Do You Own Your Benefit

As discussed earlier in this Summary, to be vested means you have a permanent right to your Plan benefit and are entitled to receive that benefit whenever you stop working for the Company. You become fully vested in your Plan benefit once you have completed 3 years of Vesting Service (5 years of Vesting Service for employees terminating

prior to January 1, 2008) (see "Service" section described earlier in this Summary). There is no partial vesting in your Plan benefit. You are not vested until you reach 3 years of Vesting Service, and you become fully vested once you reach 3 years of Vesting Service (5 years for employees terminating prior to January 1, 2008).

Thus, for example, if you terminate employment with only 2 years of Vesting Service, then you will receive no benefit under the Plan. That is, you are not vested in your benefit because you have less than 3 years of Vesting Service. If you terminate employment with 3 or more years of Vesting Service, you are fully vested in your benefit.

RECEIVING YOUR BENEFIT

When Is Your Benefit Paid?

Provided you are vested in your benefit as described above, you (or your beneficiary) may receive or begin to receive your benefit under the Plan as soon as possible following: (1) your termination of service with the Company or an affiliate; or (2) your death (see "Death Benefits" found later in this Summary).

If you are vested in your benefit and terminate employment with the Company, you may receive your benefit at any time after your termination.

If the present value of your Account is $1,000 or less at the time of termination of employment, you will automatically be paid a single lump sum cash distribution as soon as practicable after your termination. If the present value of your Account is more than $1,000, once you have terminated employment, you may elect to begin receiving your Plan benefit or you may defer receipt of your benefit until a later time, such as the date you would have reached Early Retirement or Normal Retirement. By law, you must begin to receive payment of your Plan benefit by April 1 of the calendar year following the later of either (1) the year you turn age 70½, or (2) the year in which you retire.

The amount you would be eligible to receive would be the amount of your Account (subject also to any Protected Benefit provisions). Remember, if you leave the Company before you are vested in your benefit, you are not entitled to a benefit under the Plan.

How Is Your Account Paid?

Regardless of *when* you receive your benefits, generally you will need to elect the *form* of your benefit. You can elect to receive your Plan benefit in an immediate single lump-sum payment or in an annuity form. Once you terminate employment, you can request a distribution of your benefit at any time in any of the forms available under the Plan (described below).

A Note on "Actuarially Equivalent" Benefits

The various benefit form options are considered to be *"actuarially equivalent"* meaning that, statistically, they should produce the same total benefit amount even though they provide very different monthly benefit payments or the benefit may be paid in a lump sum. To calculate actuarial equivalence, the Plan uses specified interest rate and mortality factors or other stated factors as set forth in the Plan. For instance, to calculate the lump-sum present value for your Protected Benefit (if applicable), the Plan uses as its interest rate the rate for 30-year Treasury Securities as published by the IRS for September of the prior year (or a minimum interest rate prescribed by the IRS if it produces a larger benefit).

Note that to receive the current year's interest rate for certain calculations, such as calculating the Protected Benefit, the last day worked must be November 30 (*i.e.*, a December 1 benefits commencement date). A December 1 benefits commencement date requires a retirement date of December 1 and filing proper paperwork (described below) with the Benefits Center at 1-888-640-3320 or by visiting the Web site at www.mysourceforhr.com on or before November 30 requesting commencement of pension distribution.

Applying for Benefits

If you are retiring, you must call the Benefits Center at **1-888-640-3320** or visit the Web site **www.mysourceforhr.com** to request a pension benefit commencement kit. If you contact by phone, please ask to speak with a Retirement Specialist.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are

included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before your first payment is processed. However, once your payments begin, you may not change the form of payment you have elected. Generally, all forms must be returned by the 10th of the month preceding the date your benefits are calculated to commence (your "**Benefit Commencement Date**"). The actual payment(s) will be made as soon as practicable following your Benefit Commencement Date.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively practicable after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Payment Options Under the Plan

When you retire or leave the Company, you may elect to receive your vested benefit under the Plan in any of the payment forms outlined below. As previously stated, various benefit forms are "actuarially equivalent."

Automatic Form of Payment

If you do not make a payment election, your benefit will be paid in the form of a "Single Life Annuity" if you are not married, or as a "50% Pop-Up Annuity" if you are married. If you are married, you may elect a different form of payment, but you must generally obtain your spouse's notarized written consent.

Lump-Sum Payment

You may receive your Account balance in a single lump-sum payment. If you select this distribution option, no further benefits would be payable from the Plan. If you are married at the time you want your pension benefit to be paid, your spouse must provide notarized written consent to the lump-sum form of payment, unless the benefit is $1,000 or less. Again, if your vested Plan benefit is $1,000 or less, the Plan automatically pays this amount as a lump-sum distribution (*i.e.*, annuity payments are not available).

Rollovers – If you receive your Account balance under the Plan in the form of a single lump sum, you may elect to roll over all or a portion of the distribution into an individual retirement account annuity ("IRA") or to another eligible retirement plan that accepts rollovers. If your benefit is $1,000 or less when you leave the Company, and you do not affirmatively elect to roll it over, then the Plan automatically pays this single lump-sum amount directly to you.

Annuity Payment Forms

If the value of your Account is over $1,000, you may choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan. If you elect this option, the value of your Account is converted to an annuity. To determine your monthly benefit, your Account balance is divided by an actuarial factor based on your age when benefits start. In calculating your benefit amount, the Plan considers the type of annuity you elect and, if applicable, your beneficiary's age. The following annuity options are available to you:

- **Single Life Annuity**—As stated above, if you are single, the single life annuity option is the automatic form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it as a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may not elect this form of payment without your spouse's notarized written consent.

- **50% Pop-Up Annuity**—As stated above, if you are married, the 50% Pop-Up Annuity (with no reduction for the value of the pop-up feature), with your spouse as the contingent annuitant, is the automatic form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form.

  If you are married, you may choose the 50% Pop-Up Annuity distribution option, naming a beneficiary other than your spouse (and with a reduction for the value of the pop-up feature), provided your spouse consents to the alternate beneficiary. Your spouse's written consent must be notarized.

If you are single, you may choose the 50% Pop-Up Annuity distribution option (also reduced for the value of the pop-up feature) naming a beneficiary of your choice.

Under the 50% Pop-Up Annuity distribution option, you receive reduced benefits monthly for your lifetime. If you die before your beneficiary, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime.

If your beneficiary dies within 60 months after your Benefit Commencement Date and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death.

If your beneficiary dies more than 60 months after your Benefit Commencement Date and before you die, your monthly payment will remain the same as when your beneficiary was living and all payments will stop at your death.

- **33-1/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 33-1/3% of your benefit for his or her lifetime. If you are married, you may not elect this form of payment without your spouse's notarized written consent.

- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized written consent.

- **75% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 75% of your benefits for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized written consent.

- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized written consent.

- **Five or Ten Year Certain and Life Annuity Option—**Under this option, you will receive a benefit for the rest of your life. However, your payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you select this option, the benefit paid to you during your life will be reduced to provide the five (or ten) year guaranteed benefit. If you are married, you may not elect this form of payment without your spouse's notarized written consent.

Payments under any of these options will be based on your Account (as well as any Protected Benefit, if applicable). Subject to the spousal consent requirements noted above, you may choose any form of distribution as well as choose any beneficiary as your joint annuitant. If you die before an elected form of distribution begins, your (or your beneficiary's) benefit will be determined as provided in the "Death Benefits" section of this Summary.

A Comparison of Payment Options

If you choose to receive your benefit as a lump sum, you will receive the total vested value of your Account (or, if greater, the benefit calculated under the Protected Benefit provisions described previously). If you choose to receive your benefit as an annuity, the total vested value of your benefit will be converted into an annuity form of payment. To determine how much any annuity option would pay, your benefit is first defined as a single life annuity. If you choose a different annuity payment option providing benefits for a beneficiary after your death, your actual payment will be reduced to reflect the cost or value of guaranteeing payments over the lives of two people. For example,

assume you are married and retiring when both you and your spouse are age 55. Assume also that your Account is valued at $200,000 and the applicable interest rate is 2.78% at the time you retire (note that the applicable interest rate fluctuates from year to year). See below for examples of estimated monthly amounts under some of the payment options that you could choose, and the amounts your surviving spouse could receive if you die after payments begin. Note that these examples do not incorporate any Protected Benefit you may have.

Payment Options	Your Monthly Benefit for Life	Your Spouse's Monthly Benefit for Life After Your Death
Lump Sum Payment *($200,000)*	None	None
Single Life Annuity	$882.88	$0.00
50% Pop-Up Annuity (unreduced for pop-up feature with spouse as beneficiary)	$844.03	$422.02
33-1/3 % Annuity	$857.28	$285.76
66-2/3% Annuity	$832.56	$555.04
75% Annuity	$826.38	$619.79
100% Annuity	$808.72	$808.72
5 Year Certain and Life Annuity	$879.35	$879.35 (paid until the end of 5-year period if participant dies before such date)
10 Year Certain and Life Annuity	$869.64	$869.64 (paid until the end of 10-year period if participant dies before such date)

Situations Affecting Your Plan Benefit

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- Subject to the rules described in the "Break in Service" section found earlier in this Summary, if your employment terminates before you have completed three years of vesting service (five years of vesting service if you terminated prior to January 1, 2008) you will not be entitled to a pension benefit and your pension benefit is forfeited.
- If you do not make the proper application for benefits, do not provide necessary information, or do not provide your current address, your pension benefits could be delayed.
- If you die before your pension benefits begin and are unmarried, your pension benefit is payable to your beneficiary, estate, or trust. See "Death Benefits" below.

- If required by a qualified domestic relations order, all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony, or marital property rights. See "In the Event of Divorce or Dissolution" below.
- If there is a mistake or misstatement about eligibility, participation, or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan Administrator has the authority to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made. In addition, in the event that an overpayment is made from the Plan and no additional payments are due to be paid, the Plan Administrator has the authority to seek reimbursement of such overpaid amounts from the Participant, Beneficiary, or other individual entitled to payment under the Plan (plus interest calculated in accordance with IRS guidance).
- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

A Note on Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Social Security benefits are not paid automatically; you must apply. You can apply for Social Security benefits no earlier than four months before the date you want your benefits to start and there are three ways to apply: (1) online at www.ssa.gov/planners/retire/applying8.html, (2) by phone by calling 1-800-772-1213, or (3) in person at your local Social Security office (visit https://secure.ssa.gov/ICON/main.jsp to locate your nearest Social Security office).

DEATH BENEFITS

Death After Pension Payments Begin

If you die after you have begun receiving your pension benefit, additional payments to a named beneficiary will depend on the form of benefit payment you selected (see "Payment Options Under the Plan" above).

Death Before Pension Payments Begin

If you die before you begin receiving your pension benefit and you were vested under the Plan at the time of your death (see "Vesting: When Do You Own Your Benefit" above), the Plan will provide pre-retirement death benefits to your spouse or other beneficiary.

The death benefit payable will equal the full value of your vested Account. If you were married on the date of your death, your surviving spouse will be entitled to a Pre-retirement Survivor Annuity equal to the value of your vested Account (or if greater, equal to the survivor annuity portion of a joint and 50% survivor annuity calculated as if you terminated employment on the date of your death and considering any Protected Benefit calculation). Generally, a "**Pre-retirement Survivor Annuity**" provides your surviving spouse with a single life annuity benefit for his or her remaining lifetime. If you do not wish for your surviving spouse to receive a Pre-retirement Survivor Annuity in the event of your death, or if you wish to name a beneficiary other than your surviving spouse to receive benefits at your death, you may, with your spouse's written consent, waive the Pre-retirement Survivor Annuity and/or elect another beneficiary.

Even if you do not elect a different form of payment, your surviving spouse may elect to receive the death benefit as follows:

- Single Life Annuity. A monthly benefit payable for the life of your spouse, commencing as of the first day of the month following your death. Alternatively, your spouse can elect to delay beginning payment of this annuity up to the date you would have attained age 65, but no later.
- Single Lump Sum. Payment in the form of a single lump sum payable as soon as practicable after your death.

If your beneficiary is someone other than your spouse, your Account will be paid out as a lump sum. Note that if the present value of the death benefit payable to your spouse or other beneficiary is $5,000 or less, the Trustee will automatically distribute your death benefit to your surviving spouse or other beneficiary in a single lump sum payment.

Death Benefit Rollovers

Your beneficiary (whether spouse or non-spouse) may elect to rollover a lump sum death benefit to an individual retirement account/annuity (IRA) or, for a spouse beneficiary, to some other qualifying retirement plan. Note that non-spouse beneficiaries must request that the Plan make a "direct rollover" to the applicable IRA (*i.e.*, the Plan pays the lump sum death benefit directly to the IRA). A non-spouse beneficiary may not receive a distribution and then try to deposit it into an IRA as a rollover. For further information, see "Rollovers" below.

Designation of Beneficiary

In anticipation of receiving your AB II Benefit, if you have not already done so, you will need to name a beneficiary of your AB II Benefit. On your beneficiary designation form, you indicate the person(s) who will receive the remaining payments of your Plan benefit, if any, in the event of your death. You may change your beneficiary at any time prior to commencing benefit payment(s) by completing and returning a new form. Contact the Benefits Center at **1-888-640-3320** or visit the Web site at **www.mysourceforhr.com** to change your beneficiary.

If you are married: By law, you must name your spouse as your beneficiary. If you wish to designate someone other than your spouse, your spouse must consent to your election in writing. The consent must be witnessed by a Notary Public and returned to the Benefits Center.

If you are single: You may name anyone as your beneficiary.

Some points on naming a beneficiary:

- If you marry, **your spouse automatically becomes your beneficiary** regardless of your previous designation, unless your new spouse consents in writing to another designation. You should notify the Benefits Center at 1-888-640-3320 of any changes in your marital status. See "In the Event of Divorce or Dissolution" (the following section) for an explanation of how a divorce may affect your beneficiary designation under the Plan.
- If you designate more than one beneficiary, payment of your Plan benefit will be divided evenly among your beneficiaries unless you designate otherwise.

Failure of Beneficiary Designation

If you do not designate a beneficiary, or if your beneficiary designation is for any reason illegal or ineffective, or if none of the beneficiaries that you have designated survives you, your Plan benefit will be paid in the following order of priority:

- your surviving spouse;
- your descendants, per stirpes; or
- to the legal representative of your estate.

Duty to Report Participant's Death

If you die while receiving pension payments, the Plan Administrator must be notified of your death so that appropriate action may be taken concerning your benefits (*e.g.,* beginning payments to a designated beneficiary; stopping payments; etc.). It is illegal for any person or entity to continue to receive after your death benefit payments that are supposed to be made only for the duration of your life. Accordingly, please advise those persons who may ultimately represent your estate, or who may be in a position to receive your benefit payments, of this legal duty to contact the Benefits Center at 1-888-640-3320 upon your death.

IN THE EVENT OF DIVORCE OR DISSOLUTION

If you are married and you go through a divorce or dissolution, such proceedings may affect your Plan benefit or your beneficiary designation under the Plan, as explained below. You must inform the Plan Administrator if you are divorced by contacting the Benefits Center at **1-888-640-3320.**

Beneficiary Designations After Divorce/Dissolution

If you are married and your marriage terminates by reason of divorce, dissolution or other similar operation of domestic relations law, any beneficiary designation you have previously made will remain unchanged. Note that while some state laws may invalidate a spousal beneficiary designation upon divorce, that is not the case under the Plan. Upon divorce, if you had named your former spouse as your beneficiary under the Plan, your beneficiary designation will not change unless you make a new beneficiary designation that revokes your prior beneficiary designation, or you remarry.

If you subsequently re-marry a different spouse, your previous beneficiary designation is *automatically* revoked and your new spouse becomes your beneficiary, unless a valid "qualified domestic relations order" provides otherwise. As explained below, a qualified domestic relations order may limit your ability to name another beneficiary in the event of a divorce or dissolution.

Qualified Domestic Relations Order (QDRO)

If you become divorced or legally separated, a specific type of court order could require that part of your benefit be paid to someone else – your former spouse, for example. This is known as a "qualified domestic relations order" ("QDRO"). By federal law, the Plan must comply with a QDRO. A QDRO is a legal judgment or decree that recognizes the rights of or support obligation toward a spouse, former spouse, child or other dependent. A domestic relations order must satisfy specific requirements to be "qualified," and it must be recognized by the Plan Administrator.

If required by a QDRO, all or a portion of your benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. A QDRO may require that your former spouse be treated as your surviving spouse for all or any part of the survivor benefits payable after your death. This means that if you re-marry, your subsequent spouse may not be treated as your surviving spouse for the portion of your benefit assigned to your former spouse if a valid QDRO so provides.

You and your beneficiaries may obtain, free of charge, a copy of the procedures used to determine the "qualified" status of a domestic relations order from the Benefits Center at **1-888-640-3320** or visit the Web site at **www.mysourceforhr.com**. You or your spouse should submit a draft version of a domestic relations order to the Benefits Center for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any court proceedings that may affect your Account, contact the Benefits Center at **1-888-640-3320**. When the Benefits Center receives notice of a pending QDRO, a hold will be placed on your Account that will prevent you from making any withdrawals until the QDRO is processed.

CHANGES IN EMPLOYMENT STATUS[7]

Rehired Employees

If You Are Rehired in the Future

If you terminate employment after becoming a Plan participant and later return to employment, you are no longer considered a Pension Eligible Employee (see the "Eligibility and Enrollment" section of this Summary). Accordingly, upon your reemployment, you will not accrue any additional benefit under the Plan. You will remain an inactive Plan participant as long as you maintain a benefit under the Plan, but you will no longer receive any additional Pay Credits to your Account. You will, however, continue to earn Interest Credits on your Account until you take a full distribution of your vested benefit from the Plan

If You Previously Were Rehired

If you previously terminated employment after becoming a Plan participant and previously returned to employment as a Pension Eligible Employee, you generally participated in the Plan immediately upon your rehire. If your benefit was not already determined under the AB II Benefit, and you returned to employment as a Pension Eligible Employee between January 1, 2008 and December 31, 2012, you were covered under the AB II Benefit at your reemployment. The Plan created an Opening Balance for you as described earlier in this Summary if you had not received a distribution of your benefit. If you had received a lump sum distribution of your prior benefit, then at your reemployment, you began participating in the AB II Benefit as a new employee (*i.e.*, with a $0 Opening Balance and 0 years of Point Service, though your prior Service counted for vesting purposes).

Additional Impacts of Rehire

Regardless of whether you are rehired as a non-Pension Eligible Employee or previously were hired as a Pension Eligible Employee, if you are/were receiving your benefits in the form of an annuity at the time of your return to employment, your annuity payments will be (or were) suspended. The unpaid portion of your prior benefit will be (or was) treated as follows:

- If you are or were rehired as a non-Pension Eligible Employee, on your subsequent Benefit Commencement Date, your benefit (if any) will be reduced by the amount of annuity benefits you received. For purposes of calculating your Pay Credits (described earlier), you are <u>not</u> credited with Point Service for your period of absence or for your period of reemployment;
- If you were rehired as a Pension Eligible Employee, the unpaid portion of your prior benefit was converted to an AB II Benefit Opening Balance as of the date of your reemployment. On your subsequent Benefit Commencement Date, your Protected Benefit (if any) will be reduced by the amount of annuity benefits you received. For purposes of calculating your Pay Credits (described earlier), you are credited with Point Service both before and after your absence from employment.

In either case, your prior Service (as well as your Service earned after your reemployment) counts for vesting purposes. Note that the suspension of benefits and any conversion to an Opening Balance may be impacted if you return to work after your Normal Retirement Age. In such instances, contact the NiSource Human Resource Benefits Department for additional details regarding the effect of reemployment on your retirement benefit.

Transfers to/from the NIPSCO Union Pension Plan

From the NIPSCO Union Pension Plan

[7] Note, for transfers to or from a Damage Prevention Coordinator position (job code NP3459) occurring between June 1, 2016 and April 30, 2019, the transfer rules provided in this "Changes in Employment Status" section may not apply. For more information regarding how a transfer to or from a Damage Prevention Coordinator position occurring between June 1, 2016 and April 30, 2019 would affect your Plan benefit, please contact the NiSource Human Resource Benefits Department.

If you transfer from a position providing coverage under the NIPSCO Union Pension Plan (the "NIPSCO Plan") to a position providing coverage under the Plan (whether as an exempt or non-exempt employee), your benefit will be determined under the AB II Benefit of the Plan, provided you are a Pension Eligible Employee under the Plan. Your benefit under the NIPSCO Plan shall end as of the date of your transfer and your benefit under the NIPSCO Plan will be converted to an AB II Opening Balance in the Plan. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer.

To the NIPSCO Union Pension Plan

If you transfer from a position providing coverage under the AB II Benefit of the Plan to a union position providing coverage under the NIPSCO Plan, your participation in the AB II Benefit of the Plan shall end as of the date of your transfer and your AB II Benefit under the Plan will be converted to an opening balance under the AB I Benefit option under the NIPSCO Plan. You will receive credit for vesting service and point service under the NIPSCO Plan for your service both before and after the transfer.

Transfers Within the Plan

Changes between Exempt and Non-Exempt Status

If you are a Pension Eligible Employee who is participating in the AB II Benefit (see "Eligibility and Enrollment" section earlier in this Summary) and you transfer between employment positions with the Company that are both covered under the Plan (*e.g.*, non-exempt to exempt (or vice versa), or between exempt or non-exempt positions within the Company), you will continue to participate in the AB II Benefit after your transfer, subject to the exception in the following sentence. If you were hired or rehired as a Pension Eligible Employee in a *non-exempt* position on or after January 1, 2010, and then transferred to an *exempt* position on or after January 1, 2010, you will no longer be a Pension Eligible Employee on and after the date of your transfer. If you fall into this category, any additional accruals to your AB II Benefit Account will cease as of the date of transfer, but you will continue to earn Interest Credits until you commence distribution of your benefit and your service following transfer shall be counted solely for purposes of vesting and determining eligibility for an early retirement benefit under the Plan (*i.e.*, for your Protected Benefit, if applicable).

If you were not a Pension Eligible Employee at your hire date, you will not become a Pension Eligible Employee through a transfer within the Plan.

Transfers to/from Affiliates

From An Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under an affiliate's pension plan *to* an employment position with the Company that is otherwise considered a Pension Eligible Employee position providing coverage under the Plan (see "Eligibility and Enrollment" found earlier in this Summary). Unless specific provisions in the Plan or an affiliate's plan provide otherwise, your benefit will be determined as set forth below. See the NiSource Human Resource Benefits Department for further information.

If you transfer from an affiliate in the following position:	to the Company in the following position:	The impact on plan benefits will be as follows:*
Non-union (exempt or non-exempt)	Non-union (exempt or non-exempt)	You will remain in the affiliate's plan and will accrue no benefit under the Plan. In accordance with the terms of the affiliate's plan, you will remain subject to your plan benefit terms in effect prior to your transfer.
Union	Non-union (exempt or non-exempt)	Your benefit under the affiliate's plan will be frozen as of your transfer date and you will begin to participate in the AB II Benefit of the Plan. Your prior benefit will remain in the affiliate's plan and you will begin participation in

		this Plan with a $0 Opening Balance. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer. With respect to your benefit under the affiliate's plan, you generally will cease to earn service for benefit accrual as of the date of transfer. However, service following transfer shall be counted for purposes of vesting and determining eligibility for an early retirement benefit under such plan.

*With respect to the above chart, please note the following exception: In order to accrue a benefit after a transfer to the Company (whether accruing under the affiliate's plan or the Plan), you must be a Pension Eligible Employee as described under "Eligibility and Enrollment." Thus, you will continue to accrue a benefit only if your most recent hire date with the affiliate is prior to the hire/rehire date needed to be considered a Pension Eligible Employee under the Plan (i.e., prior to January 1, 2010 for transfers to an exempt position or prior to January 1, 2013 for transfers to a non-exempt position). For example, if you were hired/rehired in a non-exempt position with an affiliate on or after January 1, 2010 and participate in the affiliate's plan, and then you transfer to an exempt position with the Company, you will not be considered a Pension Eligible Employee and will not participate in the Plan (or the affiliate's plan). If you are actively accruing a benefit in the affiliate's plan and after your transfer you are not considered a Pension Eligible Employee, your benefit will be frozen as of the date of transfer.

Note also that if an employee is not considered a "Pension Eligible Employee" under an affiliate's plan and he/she transfers to the Company, the employee will not become a Pension Eligible Employee through a transfer to the Plan.

To An Affiliate

The following chart generally describes the impact on your pension benefit if you are a Pension Eligible Employee and you transfer *from* a particular employment position providing coverage under the AB II Benefit of the Plan *to* an employment position with an affiliate that does not sponsor the Plan (because the affiliate offers a different plan or no plan). Unless specific provisions in the Plan or an affiliate's plan provide otherwise, your benefit will be determined as set forth below. See the NiSource Human Resource Benefits Department for further information.

If you transfer from the Company in the following position:	**to an affiliate in the following position:**	**The impact on plan benefits will be as follows:***
Non-union (exempt or non-exempt)	Non-union (exempt or non-exempt)	You will remain in the AB II Benefit of the Plan and will continue to earn Vesting Service and Point Service under the Plan after the transfer.
Non-union (exempt or non-exempt)	Union	Your AB II Benefit Account in the Plan will be frozen as of the date of your transfer, but will continue to earn Interest Credits until you commence distribution of your benefit. With respect to your benefit under the Plan, you generally will cease to earn service for benefit accrual as of the date of transfer. However, service following transfer shall be counted for purposes of vesting and determining eligibility for an early retirement benefit under the Plan (i.e., for your Protected Benefit, if applicable). You will begin participating in the affiliate's plan as a new participant (assuming you are classified as a "Pension Eligible Employee" under that plan). If the affiliate's plan provides for your participation in an AB I or AB II Benefit option, you shall begin participation in such option with a $0 opening balance, though you will receive credit for vesting service and point service both before and after the transfer.

*With respect to the above chart, please note the following exception: If you transfer to a position with an affiliate that does <u>not</u> consider you to be a "Pension Eligible Employee" under the affiliate's plan (due to your most recent hire date with the Company), you will not be eligible to participate in the affiliate's plan nor continue to participate in the Plan. Thus, for example, if you were hired or rehired as a Pension Eligible Employee in a non-exempt position under the Plan on or after January 1, 2010, and then transfer to an exempt position with an affiliate, you will no longer be a Pension Eligible Employee under the Plan or the affiliate's plan on and after the date of your transfer. If you are actively accruing a benefit in the Plan, that benefit will be frozen as of the date of transfer, but will continue to earn Interest Credits until you commence distribution of your benefit and your service following transfer shall be counted solely for purposes of vesting and determining eligibility for an early retirement benefit under the Plan.

If you are a Pension Eligible Employee and transfer from employment providing coverage under the Plan to a union or a non-union position with an affiliate that does sponsor the Plan, then you will remain in the AB II Benefit of the Plan (assuming you continue to be considered a Pension Eligible Employee).

If You Continue to Work After Normal Retirement Age

If you choose to work beyond your Normal Retirement Age, you will continue to earn Pay Credits and Interest Credits until you retire. If you work 40 or more hours per month on and after reaching Normal Retirement Age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching Normal Retirement Age, you may begin receiving your pension benefit from the Plan.

If You Become Disabled

If you become Disabled while working for the Company, the calculation of your Plan benefit will be impacted as described in this section. In general, "**Disability**" or "**Disabled**" under the Plan means any physical or mental condition that constitutes a disability under the long-term disability plan (the "LTD Plan") maintained by the Company. A Disability commences when you first qualify for benefits under the Company's LTD Plan and ceases when you no longer qualify for benefits under such LTD Plan.

If you are considered Disabled under the Plan and later return to active employment as a Pension Eligible Employee, you will continue to be covered under the AB II Benefit once you return to active work. Note that if not already considered an AB II Participant, any Disabled Pension Eligible Employee became an AB II Participant (effective as of January 1, 2012 for any exempt Pension Eligible Employee and effective as of January 1, 2013 for any non-exempt Pension Eligible Employee). Note that you will only continue to accrue benefits under the Plan if prior to the commencement of your Disability you were a Pension Eligible Employee and you remain a Pension Eligible Employee after your return to active employment.

Service Crediting. If you are considered Disabled under the Plan, you will continue to earn Vesting Service and Point Service while the Disability continues without regard to whether the Disability lasts beyond one year and could thus constitute a "Severance from Service" (as defined in the Plan). Point Service under the Disability provision shall cease to be credited as of the earliest of (1) the date on which your Disability ends pursuant to the Company LTD Plan (which shall be deemed your "Termination of Service" (as defined in the Plan) unless you return to employment with the Company or unless the Company determines a different "Termination of Service" date), (2) the date on which you return to employment, or (3) the date your benefit under the Plan commences.

Your Account. You will continue to receive Pay Credits and Interest Credits to your Account while you are Disabled. For these purposes, you will be deemed to receive Eligible Pay at the same level of Eligible Pay in effect for the month when you became Disabled (but excluding any performance-based components of Eligible Pay). See the "How the Plan Works" section earlier this summary for an explanation of what compensation counts as Eligible Pay.

You may elect to start your Plan benefit payments at any time once you are considered to have terminated employment by the Company. You may receive your benefit under any of the payment options described in "Payment Options Under the Plan" above. Note that if you elect to begin benefit payments, you will stop earning Pay Credits and Interest Credits. In addition, commencing your Plan benefit might mean that your LTD benefits would no longer be payable. For more information about electing payment of your Plan benefit and whether such an election would impact your LTD payments, contact the Benefits Center at 1-888-640-3320 and consult your LTD Plan.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

As stated above, to request your Plan benefits you must obtain a pension benefit commencement kit from the Benefits Center (1-888-640-3320; www.mysourceforhr.com).

Claim Denial and Appeal Process

If you disagree with any decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the administrative review procedure you must follow. If you think benefits owed to you are not paid, or are too low, or are paid at a time other than when you think they should be, you can make a "claim" for benefits to the Plan Administrator.

If your claim for a pension benefit is denied in whole or in part, you have the right to request a review of the denial. You (or your beneficiary) will be notified of a denial of your claim in writing by the Plan Administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice of the denial will include:

- The specific reason(s) for the denial;
- Specific reference to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan Administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the NiSource Benefits Committee at the following address:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Notwithstanding the foregoing, if the NiSource Benefits Committee's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the final determination may be made within the period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii) in lieu of the 60-day period (120-day period if extended due to special circumstances) described above.

If your appeal is denied, you will be told why and which Plan provisions support that decision. If the final determination is made in your favor, the determination shall be binding and conclusive. If the final determination is not made in your favor, the determination shall be binding and conclusive unless you notify the NiSource Benefits Committee within 90 days after the mailing or delivery of the determination that you intend to institute legal proceedings under Section 502(a) of ERISA challenging the determination, and you actually institute such legal proceedings within 180 days after such mailing or delivery. All questions arising with respect to the Plan during any such legal proceedings shall be governed by Indiana law, except to the extent superseded by federal law.

TAX CONSEQUENCES

How and When Your Plan Benefits are Taxed

Generally, federal and state income tax laws do not require you to pay tax on your Plan benefits until you actually receive distributions under the Plan. Once you begin to receive benefit payments, you will have taxable income on these payments in the year that you receive them. In the year(s) of any distribution from the Plan, you will receive a tax form that will provide you with the information you need to file your taxes. You may be able to defer federal income taxes and avoid any penalty taxes if you transfer or "roll over" your distribution (see the Rollover section below). You should consult your tax advisor concerning any distribution you receive from the Plan.

Withholding Requirements

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA, including a Roth IRA (see the Rollover section below). You should consult with your personal tax adviser regarding this matter.

Rollovers

If you receive your benefit under the plan in the form of a single lump-sum, you may elect to roll over all or a portion of the distribution to an Individual Retirement Account/Annuity (an "IRA") or into another retirement plan that accepts rollovers from qualified plans. If you directly roll over your distribution from the Plan into a traditional IRA or another retirement plan, no income tax will be due on the amount rolled over and earnings thereon until you begin withdrawing the funds from the traditional IRA or retirement plan. If you roll over your distribution to a Roth IRA, the amount rolled over *is* subject to income tax in the year of the rollover. Under certain circumstances, all or a portion of a distribution may not qualify for rollover treatment.

As stated above, if you elect to have your benefit paid directly to you in a lump-sum payment, rather than rolled over, 20% of your distribution will be withheld and paid to the IRS. Even if you elect to have your benefit paid directly to you, you may still decide to roll over all or a portion of your distribution to an IRA or another retirement plan. If you decide to roll over your distribution, you must make the rollover within 60 days after you receive the distribution. If you choose to roll over 100% of your distribution, you must replace the 20% that has been withheld with other money available to you within the 60-day period. If you do not replace the 20% that has been withheld and you roll over only the 80% that you actually received, you will be taxed on the 20% that was withheld.

Note that in contrast to a single lump-sum payment, you cannot roll over monthly benefit payments into an IRA or another retirement plan.

Distributions Prior to Age 59 ½

In addition to being taxed as ordinary income, the taxable portion of a distribution taken prior to age 59 ½ (an early distribution) may be subject to a nondeductible federal penalty tax of 10%. Additional penalties may exist under state tax law. Early distributions are exempt from federal penalty taxes if the distribution was made for one of the following reasons:

- Distribution to your named beneficiary due to your death;
- Distribution that is made in the form of annuity payments over your life expectancy or over the life expectancy of you and your beneficiary;

- Distribution is made after termination of employment if you terminate after you reach age 55;
- Distribution that is made because you are totally and permanently disabled;
- For deductible medical expenses;
- Payment to an alternate payee under a qualified domestic relations order upon dissolution of a marriage; or
- To roll over to an IRA or other retirement plan within 60 days of receipt.

Please contact your Plan Administrator to receive a copy of the Special Tax Notice regarding payments from the Plan. This notice contains important information that you need to know before making a payment/withholding election.

AMENDMENT OR PLAN TERMINATION

The Committee expects to continue the Plan, but reserves the right to suspend, amend, modify or terminate the Plan in whole or in part at any time. If the Plan is amended, the amendments will not decrease your Accrued Benefit as of the time an amendment is adopted.

The Committee may only amend the Plan in writing. Any amendment shall be duly authorized if approved or ratified by the Committee. Thus, the Plan may not be modified or amended simply by representations, oral or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or human resources representative, for instance. If you believe you have received information that is contrary to the terms of the Plan or this Summary, please contact the Plan Administrator for clarification or confirmation.

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be fully vested as of the date of the termination. Benefits will be paid, according to law, as described in the following paragraph. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan assets would be used to pay benefits to retirees, beneficiaries and active participants, up to the total amount of assets in the Plan's trust. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made in the following order of priority: (1) benefits that are being paid or that will begin to be paid within three years; (2) benefits guaranteed by the Pension Benefit Guaranty Corporation; (3) benefits that were already vested before the Plan's termination; and (4) all other benefits.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Your Benefits are Insured

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the Benefits Center at **1-888-640-3320** or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

ADMINISTRATIVE / LEGAL OVERVIEW

Administrative Information

Plan Sponsor

The Plan Sponsor is NiSource Inc.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee (the "Committee"). In its discretion, the Committee may designate members of the NiSource Human Resources Department or other individuals to act on its behalf with respect to the administration of the Plan. The Committee has the sole authority to interpret the terms of the Plan. You may contact the Committee/Plan Administrator at:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-4334

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for NiSource is 35-0552990.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 001. The AB II Benefit is a cash balance plan. The Plan name is the NiSource Salaried Pension Plan. Note that a collective master trust applies to the assets of the Plan as well as the assets of the NIPSCO Union Pension Plan. While the Plan and the NIPSCO Union Pension Plan have different plan documents and provisions, the two plans are collectively filed with the IRS as the "NiSource Pension Plan."

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan Trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Committee's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the Plan Trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Legal Information/Issues

Employment Rights

The Plan is neither a contract for employment nor consideration for employment. Participation in the Plan is not a guarantee of or contract for new or continued employment. All employees remain subject to termination, layoff, or discipline as if the Plan had never been put into effect.

If the Plan Becomes "Top-Heavy"; A Legal Limitation

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $175,000 (indexed for 2018), and employees who are 1 percent owners of the Company with annual compensation of more than $150,000 (not indexed), 5 percent owners of the Company, and beneficiaries of the above. You will be notified if this affects you.

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Manager, Benefits Accounting & Compliance
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan Administrator or the Plan Trustee.

Governing Law and Venue

Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law. Any suit, action, or proceeding related to the Plan or benefits under the Plan shall be brought in any court of the State of Indiana and of the United States for the Northern District of Indiana.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnished, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the

U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (Social Security retirement age) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension 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 your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.
- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), 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 NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the "Publications Hotline" of the EBSA.

OUTSIDE BACK COVER

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NiSource Inc.

Summary Plan Description

for the

Columbia Energy Group Pension Plan

A Description of Your Retirement Pension Benefits

For Employees in the
AB II Benefit
January 2019

Contents

INTRODUCTION

Retirement can be the most exciting time of your life. Of course, you must work hard and save during your career to achieve the kind of financial security needed to enjoy those years to the fullest. Early on, you will need to ask yourself: "What sources of income will I have for my retirement?" You will likely be relying on (1) your pension benefit from the **Columbia Energy Group Pension Plan** (previously known as the Retirement Plan of Columbia Energy Group Companies, hereinafter referred to as the "**Plan**"), (2) a retirement benefit from Social Security, (3) your own personal savings, and (4) if applicable, savings under the NiSource Inc. Retirement Savings Plan or any other employer-sponsored retirement plan. Your employer, a Columbia Gas company, offers the Plan for the benefit of its employees and their beneficiaries in order to help provide for retirement.

Overview of the Plan

An innovative retirement plan that helps you prepare more effectively for your future, the Plan is a defined benefit pension plan funded entirely by contributions from NiSource Inc. or its affiliates. Its purpose is to provide you with retirement income that is in addition to any other retirement income you have or may be eligible to receive.

As an employee of a Columbia Gas company or any affiliate that adopts the Plan for its employees (collectively, the "Company") satisfying the criteria described in the "Eligibility and Enrollment" section, you are eligible for the AB II Benefit of the Plan. Note that if you are a union employee of the Company, you will not participate in the AB II Benefit unless the collective bargaining agreement that covers you provides for your participation.

Introduction to the AB II Benefit

You are covered under the **AB II Benefit** of the Plan. The AB II Benefit (formerly the "Account Balance 2011 Option Benefit") is a "cash balance" option that makes it easy to understand your retirement benefit under the Plan. This option is unique because it offers you both a visible and a portable benefit.

Once you become a participant in the Plan, the Company sets up a bookkeeping account in your name. Each year, the Company adds *pay credits* equal to a percentage of your pay to your account. Your account also grows with interest in the form of annual *interest credits* throughout your career. The total of these pay credits and interest credits, plus, if applicable, any "opening balance" reflecting the benefit you earned prior to becoming an AB II Benefit participant make up your account balance. Periodically (in general, annually), you will receive personalized statements showing your current account balance. Because you will always see your account balance, you can easily monitor the growth of your retirement benefit – so your benefit is *visible*. When you retire, you can choose to receive your account balance in one of several payment methods (also explained in more detail later in this Summary). What's more, you are entitled to receive the "vested" portion of your account balance if you leave the Company prior to retirement, so your benefit is also *portable*.

Again, it costs you nothing to participate because the Company makes all contributions necessary to fund your AB II Benefit under the Plan on your behalf.

About this Plan Summary and Plan Administration

This handbook serves as a Summary Plan Description ("SPD" or "Summary") of the Plan, prepared in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. This SPD does not extend or change the Plan in any way.

The NiSource Benefits Committee (the "Committee") serves as business manager and administrator for the Plan (the "Plan Administrator"). The Plan Administrator utilizes the NiSource Human Resource Benefits Department and other specified individuals to carry out a number of administrative tasks for the Plan. See "Administrative Information" found later in this Summary. A trust fund has been established for the purpose of holding funds contributed to the Plan. The trust fund is administered by a trustee (the "Trustee") appointed by the Committee.

While the Committee intends to continue the Plan described in this handbook, the Committee reserves the right to change, modify, or discontinue the Plan and any of its terms at its discretion, subject to any applicable collective bargaining agreement.

HIGHLIGHTS: AB II BENEFIT

ARE THERE EMPLOYEE CONTRIBUTIONS?	No, all contributions are made by the Company.
ARE THERE COMPANY CONTRIBUTIONS?	Yes; the Company makes contributions to fund your AB II Benefit, which is based on: • Your age; • Your years of service; • Your Eligible Pay, taking into consideration the Social Security Taxable Wage Base; and • The Plan's interest credit rate (currently the annual interest rate on 30-year Treasury Securities as published by the IRS for the month of September immediately preceding the first day of the Plan Year, but no less than 4%)
WHEN AM I VESTED IN MY BENEFIT?	You are fully vested after 3 years of service (if you terminated prior to January 1, 2008, you generally were vested after 5 years of service).
WHAT IS ELIGIBLE PAY FOR PURPOSES OF DETERMINING MY BENEFIT?	In order to calculate your pay credits under the Plan, Eligible Pay includes your base salary and commissions, plus your performance based pay (such as bonuses or annual incentives) paid in or prior to the month of your termination of service, any salary reduction contributions made for a Company cafeteria or 401(k) plan, any "banked" vacation paid under the NiSource Vacation Policy, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay), and, for certain participants on active duty in the uniformed services, differential wage payments. However, the Plan does <u>not</u> consider certain items to be Eligible Pay. These excluded items include, but are not limited to, overtime, shift differential pay, amounts deferred to a nonqualified plan, and other special forms of pay such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income. In addition, the Plan also excludes from Eligible Pay any unused and accrued vacation paid on or after your termination of service. Note again, Eligible Pay excludes any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance based pay) when paid in any month following your termination of service.
WHEN IS MY BENEFIT PAID?	Provided you are vested, you can be paid: • When you terminate employment; • When you retire; • When you reach age 70-1/2 and are a terminated employee (payments <u>must</u> begin at this time); or • In the event of your death
HOW CAN I RECEIVE MY BENEFIT?	You may elect to receive your benefit in the form of: • One of several Monthly Annuity Options

	• A Lump Sum • A Rollover

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be a "Pension Eligible Employee" of the Company to actively participate in the Plan. Generally, you are eligible to participate in the AB II Benefit of the Plan (*i.e.*, you are a "Pension Eligible Employee" who is an "AB II Participant") if you are a regular full-time or part-time employee and fall within one of the categories described in the box below. A Pension Eligible Employee is any of the following: (1) an "exempt employee" (as classified by the Company) whose most recent hire date is before January 1, 2010; (2) a non-union "non-exempt employee" (as classified by the Company) whose most recent hire date is before January 1, 2013; or (3) a union employee whose most recent hire date is before January 1, 2013.[1] In other words, if you are an exempt employee hired or rehired on or after January 1, 2010 or a non-exempt or union employee hired or rehired on or after January 1, 2013, you are not a Pension Eligible Employee and not eligible to participate in the Plan. In addition, you are not eligible to participate if you are an intern, an independent contractor, or a leased employee of the Company, or if you are a union employee whose collective bargaining agreement does not provide for Plan participation.

More specifically, an AB II Participant is:

- All *exempt* employees (except exempt employees hired or rehired on or after January 1, 2010), including:
  - -- Any exempt employee newly hired or rehired on or after October 1, 2005 but before January 1, 2010;
  - -- Any exempt employee who elected to participate in the AB II Benefit effective January 1, 2006*;
  - -- Any exempt employee on long-term disability as of October 1, 2005 who returned to active employment and who elected to participate in the AB II Benefit or who automatically transitioned to the AB II Benefit effective upon return to employment; and
  - -- All other exempt employees who are participating in the Plan and transitioned to the AB II Benefit effective January 1, 2011 (January 1, 2012 for Disabled exempt employees).
- All *non-exempt* employees (union and non-union) (except non-exempt employees hired or rehired on or after January 1, 2013), including:
  - -- Any non-exempt (union or non-union) employee newly hired or rehired on or after January 1, 2008 but before January 1, 2013.
  - -- All other non-exempt (union and non-union, active and Disabled) employees who are participating in the Plan and transitioned to the AB II Benefit effective January 1, 2013.
- Certain other persons who are allowed to elect to participate in the AB II Benefit pursuant to terms of the Plan.

***Note:** Each non-union exempt employee who participated in the Final Average Pay Benefit ("FAP Benefit") or the AB I Benefit of the Plan had the opportunity to make an irrevocable Plan choice in December 2005 to stay in his or her current option or switch to the AB II Benefit ("Choice"). If no Choice was made, the employee remained in his or her option under the Plan. The 2005 Choice elections were made and documented in a manner specified by the Plan.

[1] Effective as of July 1, 2015, NiSource Inc. implemented the spin-off of its pipeline and transmission business, comprised of Columbia Pipeline Group, Inc. and its related entities (collectively, the "CPG Entities"), to become independent and unrelated to NiSource Inc. (the "Spin-off Transaction"). The former employees of NiSource Inc. or the Company who transferred to the CPG Entities as a result of the Spin-off Transaction are no longer eligible to participate in the Plan.

When Your Participation Begins

If you met the eligibility requirements, your participation started on your first day of work with the Company. Once you started to participate in the Plan, you continue to participate as long as you are a Pension Eligible Employee of the Company. Note again that if you terminate employment and are rehired, you are not a Pension Eligible Employee and you are no longer eligible to earn additional benefits under the Plan (though you will continue to earn interest credits on your vested account).

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer a Pension Eligible Employee (*i.e.*, you terminate employment or your employment status changes to one that is not eligible to participate in the Plan);*
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

* Note that once you are no longer a Pension Eligible Employee, you will remain an inactive Plan participant (continuing to earn interest credits on your vested account) until you take a full distribution of your vested benefit from the Plan.

Service

Your Service with the Company and its predecessors, and also any breaks in your Service, have an effect on your participation in and benefits under the Plan. As explained in the following paragraphs, your "Service" with the Company is used as a component to calculate your benefit under the Plan. Also, the Plan uses Service to determine when you are entitled to (or "vested" in) your benefit under the Plan. Note that if you terminate and return to work, you are no longer a Pension Eligible Employee and will no longer earn Point Service under the Plan upon your return to work. However, you will earn additional Vesting Service as described below.

Point Service

"Point Service" is the number of your years and partial years (*i.e.*, months) of Service as an employee of the Company (or any eligible affiliate of the Company) from the first day of the month in which your employment began through the last day of the year in which your termination of employment, for any reason, occurs. Notwithstanding the foregoing, if you were a FAP Benefit Participant who voluntarily elected to become an AB II Participant, your Point Service for the period prior to your conversion to the AB II Benefit is equal to the amount of credited service you earned prior to your conversion. Point Service is used to determine, in part, the amount of pay credits that are added to your Account. Please see the "How the Plan Works" section later in this Summary for a complete explanation of how your pay credits are calculated.

Vesting Service

"Vesting Service" is the number of your years of Service as an employee of the Company (or any affiliate) from your date of employment through the date of your termination of employment for any reason. To be "vested" means you have a non-forfeitable right to your Plan benefit. You are fully vested in your pension benefit after completing three years of Vesting Service with the Company and/or an affiliate. Note that if you terminated prior to January 1, 2008, you generally had to complete five years of Vesting Service before becoming fully vested in your benefit (unless you terminated at a time when an even higher vesting requirement applied, in which case the terms of the Plan in effect at your termination will control).

Special rules may apply if you experience a break in service, become Disabled (as defined in "If You Become Disabled" found later in this Summary) or if you were previously a leased employee of the Company or an affiliate.

Break in Service

A break in employment (called a "Break in Service") may affect how you are credited with Vesting Service under the Plan. With respect to Vesting Service, a Break in Service occurs if you terminate employment with the Company and are not employed for a period of 12 consecutive months. If you incur a Break in Service, the effect on your Vesting Service will depend on the following: (1) the length of your Break in Service and (2) whether you were vested in your pension benefit prior to the Break in Service.

Note again that if you terminate and return to work, you are no longer a Pension Eligible Employee and will no longer earn Point Service under the Plan upon your return to work. Accordingly, the following Break in Service provisions only apply for purposes of determining your Vesting Service. If you experience a transfer of employment within the Company or from/to an affiliate of the Company, see the section entitled "Changes in Employment Status" later in this Summary for an explanation of the impact on your benefit and Service crediting under the Plan.

Break in Service Less Than 1 Year

If you terminate employment and are reemployed by the Company within 12 consecutive months, you are not considered to have a Break in Service. In this case, your hours of Service earned prior to your termination of employment will be reinstated and the Plan will consider your period of absence as part of your Vesting Service under the Plan.

Break in Service of 1 to 5 Years

If you terminate employment and your Break in Service lasts more than 1 year but less than 5 years, the Vesting Service you earned before your termination will be added to the Vesting Service you earn after you return to work for vesting purposes under the Plan. If you are re-employed, the period of your absence will not count as part of your Vesting Service for any purpose.

Break in Service More Than 5 Years

If you are not vested in your pension benefit prior to your Break in Service, and your Break in Service lasts for 5 or more years, you will lose credit for all of your prior Vesting Service and will forfeit the unvested pension benefit accrued prior to your Break in Service.

If you are vested when you terminate employment and you are later re-employed after a Break in Service of 5 or more years, you will remain vested upon your return to work.

Effect of Leaves on Break in Service

If you are on an "Authorized Leave of Absence" as discussed below, the Break in Service rules do not apply to the extent you continue to earn Service during the authorized leave. If the authorized leave provisions don't apply and you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement, then different rules apply when determining if a Break in Service has occurred. In general, if you are absent from work for one of the foregoing reasons beyond the first anniversary of the first date of your absence, you will not be considered to have a severance from Service until the second anniversary of the first date of your absence. In addition, you will not have a Break in Service if you are on an Authorized Leave of Absence pursuant to the Family and Medical Leave Act, or if you are absent from employment due to service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")) and if you return to work at the end of your Authorized Leave of Absence.

Other Circumstances Impacting Service

Authorized Leaves of Absence. If you are on a leave of absence that is approved by the Company in accordance with its procedures and the Plan (an "Authorized Leave of Absence"), you will continue to earn Vesting Service and Point Service while the authorized leave continues for a period of up to 12 months. Service crediting will cease as

of the expiration of the 12 month period or, if earlier, the date the Authorized Leave of Absence ends (unless you return to work at that time).

Disability. Vesting Service and Point Service are also impacted if you become Disabled (as defined in the Plan). For information on how the Plan defines "Disability", and to learn how a Disability affects your benefit and the Service you earn under the Plan, see "If You Become Disabled" found later in this Summary.

HOW THE PLAN WORKS

As explained at the beginning of this Summary, the AB II Benefit of the Plan is a "cash balance" pension plan. A cash balance pension plan is just like other pension plans in that it can provide you with a guaranteed monthly pension benefit for life after you retire. A cash balance plan is different from other pension plans in how it defines what your benefit will be. "Traditional" pension plans use a formula, often based on your years of service and average pay leading up to retirement, to define how much your monthly pension will be. Under this kind of plan, it is hard to know the value of what you will ultimately receive when you retire until you near or reach retirement.

A cash balance plan is designed to help you better understand the value of your benefit. Instead of using a formula to define your monthly retirement pension, a cash balance plan provides an accounting of the value of your benefit (the value of your **AB II Benefit**, also known as your "**Account**"). Your benefit is based on the value of the Account kept for you. As you work, credits are made to your Account. When you retire, you will receive the value of your Account in one of the payment forms available under the Plan (these are explained in detail later in this Summary).

Also, while most traditional pension plans only let you receive your benefit as a monthly payment (*i.e.*, an annuity), the AB II Benefit gives you the option of receiving a single lump sum cash payment. In addition, while many traditional defined benefit plans provide your benefit as a monthly annuity that ends at your death or your surviving spouse's death,[2] with the AB II Benefit you can name any beneficiary to receive your benefit in the event of your death, such as a child or unrelated beneficiary, provided the consent requirements explained later in this Summary are satisfied.

Your Account

The Company sets up an account in your name (your "Account") once you become a participant in the Plan. Your Account is a bookkeeping account maintained for plan administration to keep track of your pay credits and interest credits and any distributions made to you from the Plan. *The dollar amount in your Account generally tells you the current cash value of the benefits payable to you at your retirement (subject also to any Protected Benefit calculation described later in this Summary)*.

Opening Balance

Transition from the FAP Benefit to the AB II Benefit. If you participated in the FAP Benefit under the Plan before becoming an AB II Benefit participant, your accrued FAP Benefit was converted to a lump sum "Opening Balance" and credited to your Account as of the date you converted to the AB II Benefit (your "Conversion Date"). The Opening Balance is calculated by following these steps:

1. The value of your accrued FAP Benefit is determined as of your Conversion Date;

2. If you became an AB II Benefit participant *on or after* the first day of the month following (or coincident with) your "Calculation Date" (defined below), then your Opening Balance will reflect an unreduced benefit;

3. If you became an AB II Benefit participant *before* the first day of the month following (or coincident with) your Calculation Date, then an early retirement reduction factor (0.25% per month) is applied based on the number of months between your Calculation Date and the later of (a) the Conversion Date or (b) the first day of the month following the date you reach age 60; and

4. The present value of the lump sum benefit is calculated using standard mortality and interest rate assumptions as provided in the Plan.

[2] The term "spouse" shall mean any individual who is lawfully married to a Plan participant under any state law, including individuals married to participants of the same sex.

For purposes of the above Opening Balance calculation, your "*Calculation Date*" is generally the date that is three years before your Normal Retirement Date. Your "Normal Retirement Date" is defined later in this Summary as the first day of the month following the later of (1) your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born), or (2) the fifth anniversary of your participation in the Plan. (Note that if you first became a participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Calculation Date is modified as follows: (1) if you first became a participant between January 1, 1976 and January 1, 1989, your Calculation Date is the first day of the month coincident with or next following your 62nd birthday; (2) if you first became a participant prior to January 1, 1976, your Calculation Date is the first day of the month coincident with or next following your 65th birthday.)

Transition from the AB I Benefit to the AB II Benefit. If you participated in the AB I Benefit under the Plan before becoming an AB II Benefit participant, your Opening Balance simply equals the balance of your AB I Benefit account as of your Conversion Date, including any Pay Credits or Interest Credits (described below) earned up to that date.

Determining Your Eligible Pay

As described below, your Pay Credits are based upon your **Eligible Pay**, which refers to the compensation on which your Pay Credits are calculated. Your Eligible Pay generally equals:

- Your annual base pay received from the Company, including
- Salary reduction contributions made for you under a cafeteria plan or a 401(k) plan, plus
- Commissions, if you are compensated in whole or in part on a commission basis, plus
- Performance-based pay such as bonuses or annual incentive payments (provided such amounts are paid in or prior to the month of your termination of service), plus
- Any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay)[3], plus
- Any amounts attributable to “banked” vacation and paid to you under the NiSource Vacation Policy, plus
- For certain participants on leave as a result of active duty in the uniformed services, differential wage payments.

However, Eligible Pay does not include all types of compensation you might receive from the Company. Specifically, items excluded from Eligible Pay include, but are not limited to the following:

- Overtime pay,
- Shift differential pay,
- Amounts deferred to a nonqualified plan,
- Any unused and accrued vacation paid on or after termination of service,
- Any portion of performance-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance based pay) that is paid in any month following your termination of service, and
- Other special forms of compensation, such as call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

[3] Included effective September 1, 2009.

In general, Eligible Pay shall be determined on a monthly basis. If you are a full-time employee paid on a monthly, semi-monthly, biweekly, or weekly basis, your monthly Eligible Pay equals one-twelfth of your annual base rate of pay last in effect for the month, plus pay inclusions described above such as actual commissions paid in the month. If you are a part-time employee, your monthly Eligible Pay equals the sum of your actual Eligible Pay, plus pay inclusions described above (such as commissions) paid to you for each pay period during the month. For purposes of determining your Pay Credits (described below), Eligible Pay means the sum of the monthly Eligible Pay for each month during the Plan Year in which you are an AB II Participant, including actual bonuses received by the Employee while actively employed in the month.

The IRS imposes a limit on the amount of Eligible Pay that may be taken into account by the Plan. As a result, Eligible Pay above $275,000 for 2018 (as adjusted annually by the IRS for cost-of-living increases) does not count for purposes of determining Pay Credits under the Plan.

Impact of Disability Leave, an Authorized Leave of Absence, or Other Absence on Your Eligible Pay: If you are participating in the Plan, and you are on a leave due to Disability (as defined in the Plan and as further described in "If You Become Disabled" found later in this Summary) or on an Authorized Leave of Absence or other absence approved by the Company, you will be deemed to receive Eligible Pay for purposes of calculating your Plan benefit during your period of leave. However, similar to service crediting described earlier, if on an Authorized Leave of Absence or other approved (non-Disability) leave, you will only receive Eligible Pay crediting for up to 12 months. Your Eligible Pay for each month during the period of pay crediting for Disability, Authorized Leave of Absence, or other approved absence (as applicable) generally shall equal one-twelfth of your annual base rate of pay last in effect for the month in which the employment absence occurred. In addition, solely for the month in which the Disability, Authorized Leave of Absence, or other approved absence begins, your Eligible Pay will include any other items that are generally included in Eligible Pay that you receive in the month the absence begins (but such amounts will not otherwise affect the rate of Eligible Compensation crediting during the absence). For more specific information on how Eligible Pay is calculated during any of the above-described absences from employment, please contact the NiSource Human Resource Benefits Department.

Pay Credits

The Plan provides for two types of Pay Credits: Basic Pay Credits and Excess Pay Credits. You are eligible to receive Basic Pay Credits and, if applicable, Excess Pay Credits effective generally as of the date you become an AB II Participant and up until the time you terminate service or otherwise stop accruing a benefit under the AB II Benefit provisions of the Plan.

The Company allocates Basic Pay Credits to your Account as of December 31 of each year. These Basic Pay Credits are equal to a percentage of your annual Eligible Pay. The total age and years of Point Service you accumulate each year, as measured on December 31, determines the annual Basic Pay Credit percentage. If you leave the Company mid-year, you will receive prorated Basic Pay Credits through your termination date.

The Company also allocates Excess Pay Credits as of December 31 of each year to qualifying participants' Accounts. Excess Pay Credits are available if you earn more than one-half of the Social Security Wage Base for that year. If you qualify, the Excess Pay Credit is 1% of your Eligible Pay that exceeds one-half of the Social Security Wage Base.

The table below shows how Basic Pay Credits and Excess Pay Credits are calculated:

AB II Pay Credits			
If your age plus years of Point Service at the end of the year total…	Less than 50	50-69	70+
Your Basic Pay Credit for that year will be equal to this percentage of your Eligible Pay…	4 %	5 %	6 %

Your Excess Pay Credit will be equal to an additional percentage of your Eligible Pay over one-half of the Social Security Wage Base* in effect that year…	1 %

*The Social Security Wage Base (SSWB) is the maximum amount of eligible pay on which you and the Company pay Social Security (or OASDI) taxes each year. For 2018, the SSWB is $128,400. Because you do not pay Social Security taxes on eligible pay in excess of the SSWB, you also do not earn Social Security benefits on eligible pay in excess of the SSWB. To help compensate affected employees, the AB II Benefit provides additional credit on pay over one-half the SSWB, which is $64,200 in 2018 ($128,400 divided by two).

Example

Assume that on December 31, 2018, a participant has attained age 40 years and 6 months and has earned Point Service of 8 years and 10 months. Because the participant will have a total age plus Point Service of 49 years and 4 months, he/she will be eligible for a Basic Pay Credit of 4%. Let's assume the participant earns $40,000 for the year. The participant would receive a Basic Pay Credit to his Account of $1,600 for 2018 (4% of $40,000). The participant would not be eligible for the Excess Pay Credit because his Eligible Pay is not in excess of one-half of the SSWB for the year. However, if the same participant's Eligible Pay were $65,000 for 2018, he would receive a Basic Pay Credit of $2,600 (4% of $65,000), plus an Excess Pay Credit of $8.00 (1% of $800, which is the excess of Eligible Pay over one-half of the SSWB).

Interest Credits

Interest is credited to your Account each Plan Year effective as of December 31 up until the time you commence retirement benefits. Interest Credits are based on the 30-year Treasury Securities Rate as published by the IRS for September of the preceding year (but not less than 4%) and are applied to your Account based on the value of your Account as of the last day of the prior Plan Year.

Your Account will continue to receive Interest Credits until you commence your retirement benefit payments under the Plan, regardless of whether you have stopped working for the Company as a Pension Eligible Employee. However, if you terminate employment with the Company before you are vested in your benefit, you will not receive Interest Credits after your termination. If you are subsequently reemployed, you will receive Interest Credits effective as of the date of your reemployment. In the year you begin receiving benefits, you will receive prorated Interest Credits for the portion of the year before the benefit starts. If you become a participant in the Plan mid-year, you will receive prorated Interest Credits from the date your participation began.

Example

Assume that on January 1, 2018, your Account is $50,000, and that the Interest Credit rate for the Plan Year is 4% (*i.e.*, the greater of the 30-year Treasury Securities rate as published by the IRS for September 2017 or 4%). On December 31, 2018, your Account would receive an Interest Credit of $2,000 (or $50,000 × 4%).

Summing it Up: How Your Account Grows

Altogether, taking into account the Pay Credit (both Basic and Excess) and Interest Credit components, your Account is thus the sum of:

- Y*our Opening Balance*, if any, under the Plan as of the beginning of the year; plus
- *Pay Credits* allocated to your Account as an annual percentage of eligible pay based on age plus Point Service as outlined in the table above; plus
- *Interest Credits* allocated to your Account based on the annual interest rate on 30-year Treasury Securities as published by the IRS for the September immediately preceding the first day of the Plan Year (but no less than 4%).

Example

With the addition of both Interest and Pay Credits each year, you can see your Account balance grow. Here is an example of how your Account can grow in one year, using the assumptions set forth below.

First, calculate the Basic and Excess Pay Credit:

If you are 49 years old, have eligible earnings of $65,000 and have completed 17 years of Point Service at the end of 2018, your 2018 Pay Credit would be calculated as follows:

Basic Pay Credit

Your 2018 Eligible Pay	$65,000
Your Basic Pay Credit % (49 + 17 = 66 points = 5%)	x 5%
Your Basic Pay Credit amount on December 31, 2018	***$3,250***

Excess Pay Credit

Your 2018 Eligible Pay over ½ SSWB ($65,000 – $64,200)	$800
Your Excess Pay Credit %	x 1%
Your Excess Pay Credit amount on December 31, 2018	***$8.00***

Your total Pay Credit on December 31, 2018 is the sum of $3,250 + $8.00 or a total of $3,258.00 for the year.

Second, add the Interest Credit:

If the interest rate is at 4% for the Plan Year, your Interest Credit would be 4% of your Account balance as of the beginning of the Plan Year. Assuming your Account balance as of January 1, 2018 was $50,000, then you received an Interest Credit effective as of December 31, 2018 equal to $2,000.

Finally, total the Pay Credits and Interest Credit, and add to the Account balance at the beginning of the year:

January 1 Account Balance (includes your "Opening Balance," if any)	$50,000
	+
December 31 Interest Credit (4%)	$2,000
	+
December 31 Basic Pay Credit (5%)	$3,250
	+
December 31 Excess Pay Credit (1%)	$8.00
December 31 Account Balance	***$55,258.00***

Remember, how your Account grows over time depends on the actual Eligible Pay you receive and the Interest Credits allocated to your Account. In other words, items impacting Eligible Pay, such as base pay increases and performance-based pay (*e.g.*, bonuses or annual incentive payments paid before employment termination) will impact how your Account will grow.

Monitoring the Growth of Your Account

To help you track the growth of your Account, you will receive personalized statements (generally on an annual basis) that will keep you up-to-date on your Account activity. These statements show your:

- Account;

- Pay Credits since the last statement;
- Any applicable Interest Credits since the last statement.

You can also obtain information on the value of your Account any time by contacting the Benefits Center at **1-888-640-3320** or by visiting the Web site **www.mysourceforhr.com**.

Benefits From Your Account

Although your Account is communicated to you as a lump-sum amount, when you leave the Company and commence benefits, as previously mentioned, your Account can provide a monthly annuity based on prevailing interest rates at the time you commence benefits. See the "Payment Options Under the Plan" section later in this Summary for details on how you may receive your benefit, and see the "Designation of Beneficiary" section for details on how you may designate your spouse or another individual to receive your benefit in the event of your death.

For example, if your Account balance on the date you commence benefits is $200,000 and the annuity factor for your age (to convert your Account to an annual benefit) at that time is 14, you would receive either a lump sum of $200,000 (minus applicable withholding taxes) or a monthly benefit for life of approximately $1,190, as follows:

Calculating Annuity Example	
Account Balance:	$200,000
Annuity Factor:	÷ 14
Annual Benefit:	$ 14,285
	÷ 12
Monthly Benefit:	$ 1,190

Protected Benefit

In addition to your Account, the Plan may also consider a "Protected Benefit" in calculating your retirement benefit.

Former FAP Benefit Participants

If you previously participated in the FAP Benefit of the Plan, your Plan benefit under the AB II Benefit is guaranteed to be no less than the sum of (1) the lump sum actuarial equivalent of your accrued benefit under the FAP Benefit (which does not include any supplemental benefit) using eligible pay and Service through your Conversion Date (your **"Protected Benefit"**), plus (2) your Pay Credits (and Interest Credits earned on those Pay Credits) under the AB II Benefit from your Conversion Date (*i.e.*, the date of conversion to your AB II Benefit) through your termination of employment.

If you are eligible for this Protected Benefit, the Protected Benefit component of your benefit could be reduced if you elect to receive it prior to your "Normal Retirement Date" to reflect early commencement of payment. Because your Protected Benefit is derived from a traditional pension plan formula, you would generally not be able to receive your benefit until you retired. As noted earlier though, one benefit of the Plan's cash balance status is that you may receive your benefits anytime after your termination of employment. However, for purposes of valuing *only* the Protected Benefit portion of your Plan benefit, the Plan will consider whether you begin to receive benefits before your "Normal Retirement Date." The following subsections describe how the calculation of your Protected Benefit may be affected by when you choose to receive your benefit.

As a reminder, your AB II Benefit is calculated as described in the preceding portions of the "How the Plan Works" section. The following subsections apply *only* for any Protected Benefit portion of your Plan benefit and *do not* apply to the calculation of your AB II Benefit. For additional information regarding your FAP Benefit (if applicable), which is the basis of your Protected Benefit, please refer to the Summary Plan Description that you received for your FAP Benefit.

Normal Retirement

If you retire on or after your "Normal Retirement Date," your Protected Benefit will be not be impacted. Your "**Normal Retirement Date**" is the first day of the month following the later of (1) your full "Social Security Retirement Age" (age 65 to 67, depending on when you were born) (your "**Normal Retirement Age**"[4], as defined under the Plan); or (2) the fifth anniversary of the date you began participation in the Plan. (Note that if you first became a participant before January 1, 1989, then solely for calculating the minimum benefit amount earned prior to January 1, 1989, your Normal Retirement Date is the first day of the month following your 65th birthday.) If you retire on or after your Normal Retirement Date, the amount of your Protected Benefit will be based on the full amount of your Protected Benefit up to your Conversion Date (*i.e.*, your benefit will not be reduced for early commencement of payment.)

Early Retirement

If you retire on or after reaching your "Early Retirement Age" (*i.e.*, on your "Early Retirement Date") but before your Normal Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. Your "**Early Retirement Date**" is the first day of the month following your employment termination on or after the date that you have (1) both attained age 60 or older and completed at least five years of Service; or (2) both attained age 55 (or older) and completed 10 years of Service. If you reach your Early Retirement Date, you may elect to receive your benefits immediately or defer the commencement of your benefits until you reach your Normal Retirement Date.

If you retire and elect to receive benefits at or after your Early Retirement Date, the amount of your Protected Benefit would be reduced by 0.25% for each month by which your Early Retirement Date precedes the first day of the month following the date that is three years prior to your Social Security Retirement Age.

If you defer the receipt of your benefits until your Normal Retirement Date, the amount of your Protected Benefit will not be reduced.

Distribution Prior to Early Retirement

If you terminate prior to your Early Retirement Date and elect to receive your Plan benefit, the Protected Benefit portion will be reduced to reflect the early commencement of your benefit. If you elect to receive your benefit prior to your Early Retirement Date, the amount of your Protected Benefit will be reduced actuarially using the interest rate and mortality factors specified in the Plan.

Former AB I Benefit Participants

As indicated earlier under the "Your Account" portion of this Summary, if you previously participated in the AB I Benefit under the Plan, your Plan benefit under the AB II Benefit will be no less than the sum of (1) the balance of your AB I Benefit account as of your Conversion Date, plus (2) your Pay Credits (and Interest Credits earned on those Pay Credits) under the AB II Benefit from your Conversion Date. If you participated in the FAP Benefit prior to transitioning to the AB I Benefit, then your Plan benefit under the AB II Benefit shall also be no less than your FAP Benefit when it was converted to the AB I Benefit.

[4] Note that reaching your "Normal Retirement Age" as defined under the Plan does not necessarily mean you are entitled to a retirement benefit from Social Security. For more information on when you may be eligible to receive benefits from Social Security, see "A Note on Social Security Benefits" later in this Summary.

Calculating Your Benefit

The calculation of your benefit under the Plan depends on how and when you wish to receive your benefit. Of course, if you terminate employment and elect to begin receiving your Plan benefit right away, your Account will have a smaller balance than if you had worked longer or waited to receive your benefits until a later date. Remember, you stop accruing Pay Credits when you terminate employment, and you no longer earn Interest Credits once you begin receiving your benefit. In addition, if you begin payment of your benefits prior to your Normal Retirement Age, your Protected Benefit (if applicable) would be reduced as explained above.

Your total benefit under the Plan is your Accrued Benefit. Your "**Accrued Benefit**" is the value of your benefit under the Plan as of any date before you reach your Normal Retirement Date. Your Accrued Benefit is generally the current value of your entire Account. However, if you have a Protected Benefit as described above, your Accrued Benefit is generally equal to the greater of:

1. Your entire Account (reflecting all Pay Credits, Interest Credits, and any Opening Balance); **or**

2. Your benefit you earned under the FAP Benefit as of your Conversion Date (*i.e.*, your Protected Benefit, which does not include any supplemental benefit), PLUS the portion of your AB II Benefit Account reflecting Pay Credits and Interest Credits earned from conversion to the AB II Benefit until termination of service (with Interest Credits continuing until commencement of benefits). In other words, the calculation under this subparagraph 2 considers your Protected Benefit plus your Account, but without consideration of any Opening Balance (or interest thereon) (*i.e.*, under this calculation, your prior FAP Benefit is considered as your Protected Benefit rather than as your Opening Balance).

If you are interested in finding out your benefit under the Plan, you may have your benefit calculated by calling the Benefits Center at 1-888-640-3320 or visiting the Web site **www.mysourceforhr.com**.

Funding: Who Pays For Your Benefit

The Plan is funded with contributions made by the Company. On an annual basis, the Plan Administrator actuarially determines the amount that the Company must contribute in order to fund the pension benefits for you and your fellow co-workers that participate in the Plan.

Vesting: When Do You Own Your Benefit

As discussed earlier in this Summary, to be vested means you have a permanent right to your Plan benefit and are entitled to receive that benefit whenever you stop working for the Company. You become fully vested in your Plan benefit once you have completed 3 years of Vesting Service (5 years of Vesting Service for employees terminating prior to January 1, 2008) (see "Service" section described earlier in this Summary). There is no partial vesting in your Plan benefit. You are not vested until you reach 3 years of Vesting Service, and you become fully vested once you reach 3 years of Vesting Service (5 years for employees terminating prior to January 1, 2008).

Thus, for example, if you terminate employment with only 2 years of Vesting Service, then you will receive no benefit under the Plan. That is, you are not vested in your benefit because you have less than 3 years of Vesting Service. If you terminate employment with 3 or more years of Vesting Service, you are fully vested in your benefit.

Notwithstanding the foregoing, if you terminated employment between January 1, 1999 and December 31, 2001, you are 100% vested in your Plan benefit, regardless of the number of years of Vesting Service you completed as of your termination of employment.

RECEIVING YOUR BENEFIT

When Is Your Benefit Paid?

Provided you are vested in your benefit as described above, you (or your beneficiary) may receive or begin to receive your benefit under the Plan as soon as possible following: (1) your termination of service with the Company or an affiliate; or (2) your death (see "Death Benefits" found later in this Summary).

If you are vested in your benefit and terminate employment with the Company, you may receive your benefit at any time after your termination.

If the present value of your Account is $1,000 or less at the time of termination of employment, you will automatically be paid a single lump sum cash distribution as soon as practicable after your termination. If the present value of your Account is more than $1,000, once you have terminated employment, you may elect to begin receiving your Plan benefit or you may defer receipt of your benefit until a later time, such as the date you would have reached Early Retirement or Normal Retirement. By law, you must begin to receive payment of your Plan benefit by April 1 of the calendar year following the later of either (1) the year you turn age 70½, or (2) the year in which you retire.

The amount you would be eligible to receive would be the amount of your Account (subject also to any Protected Benefit provisions). Remember, if you leave the Company before you are vested in your benefit, you are not entitled to a benefit under the Plan.

How Is Your Account Paid?

Regardless of *when* you receive your benefits, generally you will need to elect the *form* of your benefit. You can elect to receive your Plan benefit in an immediate single lump-sum payment or in an annuity form. Once you terminate employment, you can request a distribution of your benefit at any time in any of the forms available under the Plan (described below).

A Note on "Actuarially Equivalent" Benefits

The various benefit form options are considered to be *"actuarially equivalent"* meaning that, statistically, they should produce the same total benefit amount even though they provide very different monthly benefit payments or the benefit may be paid in a lump sum. To calculate actuarial equivalence, the Plan uses specified interest rate and mortality factors or other stated factors as set forth in the Plan. For instance, to calculate the lump-sum present value for your Protected Benefit (if applicable), the Plan uses as its interest rate the rate for 30-year Treasury Securities as published by the IRS for September of the prior year (or a minimum interest rate prescribed by the IRS if it produces a larger benefit).

Note that to receive the current year's interest rate for certain calculations, such as calculating the Protected Benefit, the last day worked must be November 30 (*i.e.*, a December 1 benefits commencement date). A December 1 benefits commencement date requires a retirement date of December 1 and filing proper paperwork (described below) with the Benefits Center at 1-888-640-3320 or by visiting the Web site at www.mysourceforhr.com on or before November 30 requesting commencement of pension distribution.

Applying for Benefits

If you are retiring, you must call the Benefits Center at **1-888-640-3320** or visit the Web site **www.mysourceforhr.com** to request a pension benefit commencement kit. If you contact by phone, please ask to speak with a Retirement Specialist.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are

included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before your first payment is processed. However, once your payments begin, you may not change the form of payment you have elected. Generally, all forms must be returned by the 10th of the month preceding the date your benefits are calculated to commence (your "**Benefit Commencement Date**"). The actual payment(s) will be made as soon as practicable following your Benefit Commencement Date.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively practicable after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Payment Options Under the Plan

When you retire or leave the Company, you may elect to receive your vested benefit under the Plan in any of the payment forms outlined below. As previously stated, various benefit forms are "actuarially equivalent."

Automatic Form of Payment

If you do not make a payment election, your benefit will be paid in the form of a "Single Life Annuity" if you are not married, or as a "50% Pop-Up Annuity" if you are married. If you are married, you may elect a different form of payment, but you must generally obtain your spouse's notarized written consent.

Lump-Sum Payment

You may receive your Account balance in a single lump-sum payment. If you select this distribution option, no further benefits would be payable from the Plan. If you are married at the time you want your pension benefit to be paid, your spouse must provide notarized written consent to the lump-sum form of payment, unless the benefit is $1,000 or less. Again, if your vested Plan benefit is $1,000 or less, the Plan automatically pays this amount as a lump sum distribution (*i.e.*, annuity payments are not available).

Rollovers – If you receive your Account balance under the Plan in the form of a single lump sum, you may elect to roll over all or a portion of the distribution into an individual retirement account annuity ("IRA") or to another eligible retirement plan that accepts rollovers. If your benefit is $1,000 or less when you leave the Company, and you do not affirmatively elect to roll it over, then the Plan automatically pays this single lump-sum amount directly to you.

Annuity Payment Forms

If the value of your Account is over $1,000, you may choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan. If you elect this option, the value of your Account is converted to an annuity. To determine your monthly benefit, your Account balance is divided by an actuarial factor based on your age when benefits start. In calculating your benefit amount, the Plan considers the type of annuity you elect and, if applicable, your beneficiary's age. The following annuity options are available to you:

- **Single Life Annuity**—As stated above, if you are single, the single life annuity option is the automatic form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it as a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may not elect this form of payment without your spouse's notarized written consent.
- **50% Pop-Up Annuity**—As stated above, if you are married, the 50% Pop-Up Annuity (with no reduction for the value of the pop-up feature), with your spouse as the contingent annuitant, is the automatic form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form.

  If you are married, you may choose the 50% Pop-Up Annuity distribution option, naming a beneficiary other than your spouse (and with a reduction for the value of the pop-up feature), provided your spouse consents to the alternate beneficiary. Your spouse's written consent must be notarized.

  If you are single, you may choose the 50% Pop-Up Annuity distribution option (also reduced for the value of the pop-up feature) naming a beneficiary of your choice.

Under the 50% Pop-Up Annuity distribution option, you receive reduced benefits monthly for your lifetime. If you die before your beneficiary, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime.

If your beneficiary dies within 60 months after your Benefit Commencement Date and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death.

If your beneficiary dies more than 60 months after your Benefit Commencement Date and before you die, your monthly payment will remain the same as when your beneficiary was living and all payments will stop at your death.

- **33-1/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 33-1/3% of your benefit for his or her lifetime. If you are married, you may not elect this form of payment without your spouse's notarized written consent.
- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized written consent.
- **75% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 75% of your benefits for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized written consent.
- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized written consent.
- **Five or Ten Year Certain and Life Annuity Option—**Under this option, you will receive a benefit for the rest of your life. However, your payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you select this option, the benefit paid to you during your life will be reduced to provide the five (or ten) year guaranteed benefit. If you are married, you may not elect this form of payment without your spouse's notarized written consent.

Payments under any of these options will be based on your Account (as well as any Protected Benefit, if applicable). Subject to the spousal consent requirements noted above, you may choose any form of distribution as well as choose any beneficiary as your joint annuitant. If you die before an elected form of distribution begins, your (or your beneficiary's) benefit will be determined as provided in the "Death Benefits" section of this Summary.

A Comparison of Payment Options

If you choose to receive your benefit as a lump sum, you will receive the total vested value of your Account (or, if greater, the benefit calculated under the Protected Benefit provisions described previously). If you choose to receive your benefit as an annuity, the total vested value of your benefit will be converted into an annuity form of payment. To determine how much any annuity option would pay, your benefit is first defined as a single life annuity. If you choose a different annuity payment option providing benefits for a beneficiary after your death, your actual payment will be reduced to reflect the cost or value of guaranteeing payments over the lives of two people. For example, assume you are married and retiring when both you and your spouse are age 55. Assume also that your Account is valued at $200,000 and the applicable interest rate is 2.78% at the time you retire (note that the applicable interest rate fluctuates from year to year). See below for examples of estimated monthly amounts under some of the

payment options that you could choose, and the amounts your surviving spouse could receive if you die after payments begin. Note that these examples do not incorporate any Protected Benefit you may have.

Payment Options	Your Monthly Benefit for Life	Your Spouse's Monthly Benefit for Life After Your Death
Lump Sum Payment *($200,000)*	None	None
Single Life Annuity	$882.88	$0.00
50% Pop-Up Annuity (unreduced for pop-up feature with spouse as beneficiary)	$844.03	$422.02
33-1/3 % Annuity	$857.28	$285.76
66-2/3% Annuity	$832.56	$555.04
75% Annuity	$826.38	$619.79
100% Annuity	$808.72	$808.72
5 Year Certain and Life Annuity	$879.35	$879.35 (paid until the end of 5-year period if participant dies before such date)
10 Year Certain and Life Annuity	$869.64	$869.64 (paid until the end of 10-year period if participant dies before such date)

Situations Affecting Your Plan Benefit

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- Subject to the rules described in the "Break in Service" section found earlier in this Summary, if your employment terminates before you have completed three years of vesting service (five years of vesting service if you terminated prior to January 1, 2008) you will not be entitled to a pension benefit and your pension benefit is forfeited.
- If you do not make the proper application for benefits, do not provide necessary information, or do not provide your current address, your pension benefits could be delayed.
- If you die before your pension benefits begin and are unmarried, your pension benefit is payable to your beneficiary, estate, or trust. See "Death Benefits" below.
- If required by a qualified domestic relations order, all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony, or marital property rights. See "In the Event of Divorce or Dissolution" below.

- If there is a mistake or misstatement about eligibility, participation, or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan Administrator has the authority to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made. In addition, in the event that an overpayment is made from the Plan and no additional payments are due to be paid, the Plan Administrator has the authority to seek reimbursement of such overpaid amounts from the Participant, Beneficiary, or other individual entitled to payment under the Plan (plus interest calculated in accordance with IRS guidance).
- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

A Note on Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Social Security benefits are not paid automatically; you must apply. You can apply for Social Security benefits no earlier than four months before the date you want your benefits to start and there are three ways to apply: (1) online at www.ssa.gov/planners/retire/applying8.html, (2) by phone by calling 1-800-772-1213, or (3) in person at your local Social Security office (visit https://secure.ssa.gov/ICON/main.jsp to locate your nearest Social Security office).

DEATH BENEFITS

Death After Pension Payments Begin

If you die after you have begun receiving your pension benefit, additional payments to a named beneficiary will depend on the form of benefit payment you selected (see "Payment Options Under the Plan" above).

Death Before Pension Payments Begin

If you die before you begin receiving your pension benefit and you were vested under the Plan at the time of your death (see "Vesting: When Do You Own Your Benefit" above), the Plan will provide pre-retirement death benefits to your spouse or other beneficiary.

The death benefit payable will equal the full value of your vested Account. If you were married on the date of your death, your surviving spouse will be entitled to a Pre-retirement Survivor Annuity equal to the value of your vested Account (or if greater, equal to the survivor annuity portion of a joint and 50% survivor annuity calculated as if you terminated employment on the date of your death and considering any Protected Benefit calculation). Generally, a "**Pre-retirement Survivor Annuity**" provides your surviving spouse with a single life annuity benefit for his or her remaining lifetime. If you do not wish for your surviving spouse to receive a Pre-retirement Survivor Annuity in the event of your death, or if you wish to name a beneficiary other than your surviving spouse to receive benefits at your death, you may, with your spouse's written consent, waive the Pre-retirement Survivor Annuity and/or elect another beneficiary.

Even if you do not elect a different form of payment, your surviving spouse may elect to receive the death benefit as follows:

- Single Life Annuity. A monthly benefit payable for the life of your spouse, commencing as of the first day of the month following your death. Alternatively, your spouse can elect to delay beginning payment of this annuity up to the date you would have attained age 65, but no later.
- Single Lump Sum. Payment in the form of a single lump sum payable as soon as practicable after your death.

If your beneficiary is someone other than your spouse, your Account will be paid out as a lump sum. Note that if the present value of the death benefit payable to your spouse or other beneficiary is $5,000 or less, the Trustee will automatically distribute your death benefit to your surviving spouse or other beneficiary in a single lump sum payment.

Death Benefit Rollovers

Your beneficiary (whether spouse or non-spouse) may elect to rollover a lump sum death benefit to an individual retirement account/annuity (IRA) or, for a spouse beneficiary, to some other qualifying retirement plan. Note that non-spouse beneficiaries must request that the Plan make a "direct rollover" to the applicable IRA (*i.e.*, the Plan pays the lump sum death benefit directly to the IRA). A non-spouse beneficiary may not receive a distribution and then try to deposit it into an IRA as a rollover. For further information, see "Rollovers" below.

Designation of Beneficiary

In anticipation of receiving your AB II Benefit, if you have not already done so, you will need to name a beneficiary of your AB II Benefit. On your beneficiary designation form, you indicate the person(s) who will receive the remaining payments of your Plan benefit, if any, in the event of your death. You may change your beneficiary at any time prior to commencing benefit payment(s) by completing and returning a new form. Contact the Benefits Center at **1-888-640-3320** or visit the Web site at **www.mysourceforhr.com** to change your beneficiary.

If you are married: By law, you must name your spouse as your beneficiary. If you wish to designate someone other than your spouse, your spouse must consent to your election in writing. The consent must be witnessed by a Notary Public and returned to the Benefits Center.

If you are single: You may name anyone as your beneficiary.

Some points on naming a beneficiary:

- If you marry, **your spouse automatically becomes your beneficiary** regardless of your previous designation, unless your new spouse consents in writing to another designation. You should notify the Benefits Center at 1-888-640-3320 of any changes in your marital status. See "In the Event of Divorce or Dissolution" (the following section) for an explanation of how a divorce may affect your beneficiary designation under the Plan.
- If you designate more than one beneficiary, payment of your Plan benefit will be divided evenly among your beneficiaries unless you designate otherwise.

Failure of Beneficiary Designation

If you do not designate a beneficiary, or if your beneficiary designation is for any reason illegal or ineffective, or if none of the beneficiaries that you have designated survives you, your Plan benefit will be paid in the following order of priority:

- your surviving spouse;
- your descendants, per stirpes; or
- to the legal representative of your estate.

Duty to Report Participant's Death

If you die while receiving pension payments, the Plan Administrator must be notified of your death so that appropriate action may be taken concerning your benefits (*e.g.,* beginning payments to a designated beneficiary; stopping payments; etc.). It is illegal for any person or entity to continue to receive after your death benefit payments that are supposed to be made only for the duration of your life. Accordingly, please advise those persons who may ultimately represent your estate, or who may be in a position to receive your benefit payments, of this legal duty to contact the Benefits Center at 1-888-640-3320 upon your death.

IN THE EVENT OF DIVORCE OR DISSOLUTION

If you are married and you go through a divorce or dissolution, such proceedings may affect your Plan benefit or your beneficiary designation under the Plan, as explained below. You must inform the Plan Administrator if you are divorced by contacting the Benefits Center at **1-888-640-3320.**

Beneficiary Designations After Divorce/Dissolution

If you are married and your marriage terminates by reason of divorce, dissolution, or other similar operation of domestic relations law, any beneficiary designation you have previously made will remain unchanged. Note that while some state laws may invalidate a spousal beneficiary designation upon divorce, that is not the case under the Plan. Upon divorce, if you had named your former spouse as your beneficiary under the Plan, your beneficiary designation will not change unless you make a new beneficiary designation that revokes your prior beneficiary designation, or you remarry.

If you subsequently re-marry a different spouse, your previous beneficiary designation is *automatically* revoked and your new spouse becomes your beneficiary, unless a valid "qualified domestic relations order" provides otherwise. As explained below, a qualified domestic relations order may limit your ability to name another beneficiary in the event of a divorce or dissolution.

Qualified Domestic Relations Order (QDRO)

If you become divorced or legally separated, a specific type of court order could require that part of your benefit be paid to someone else – your former spouse, for example. This is known as a "qualified domestic relations order" ("QDRO"). By federal law, the Plan must comply with a QDRO. A QDRO is a legal judgment or decree that recognizes the rights of or support obligation toward a spouse, former spouse, child, or other dependent. A domestic relations order must satisfy specific requirements to be "qualified," and it must be recognized by the Plan Administrator.

If required by a QDRO, all or a portion of your benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony, or marital property rights. A QDRO may require that your former spouse be treated as your surviving spouse for all or any part of the survivor benefits payable after your death. This means that if you re-marry, your subsequent spouse may not be treated as your surviving spouse for the portion of your benefit assigned to your former spouse if a valid QDRO so provides.

You and your beneficiaries may obtain, free of charge, a copy of the procedures used to determine the "qualified" status of a domestic relations order from the Benefits Center at **1-888-640-3320** or visit the Web site at **www.mysourceforhr.com**. You or your spouse should submit a draft version of a domestic relations order to the Benefits Center for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any court proceedings that may affect your Account, contact the Benefits Center at **1-888-640-3320**. When the Benefits Center receives notice of a pending QDRO, a hold will be placed on your Account that will prevent you from making any withdrawals until the QDRO is processed.

CHANGES IN EMPLOYMENT STATUS

Rehired Employees

If You Are Rehired in the Future

If you terminate employment after becoming a Plan participant and later return to employment, you are no longer considered a Pension Eligible Employee (see the "Eligibility and Enrollment" section of this Summary). Accordingly, upon your reemployment, you will not accrue any additional benefit under the Plan. You will remain an inactive Plan participant as long as you maintain a benefit under the Plan, but you will no longer receive any additional Pay Credits to your Account. You will, however, continue to earn Interest Credits on your Account until you take a full distribution of your vested benefit from the Plan.

If You Previously Were Rehired

If you previously terminated employment after becoming a Plan participant and previously returned to employment as a Pension Eligible Employee, you generally participated in the Plan immediately upon your rehire. If your benefit was not already determined under the AB II Benefit, and you returned to employment as a Pension Eligible Employee between January 1, 2008 and December 31, 2012, you were covered under the AB II Benefit at your reemployment. The Plan created an Opening Balance for you as described earlier in this Summary if you had not received a distribution of your benefit. If you had received a lump sum distribution of your prior benefit, then at your reemployment, you began participating in the AB II Benefit as a new employee (*i.e.*, with a $0 Opening Balance and 0 years of Point Service, though your prior Service counts for vesting purposes).

Additional Impacts of Rehire

Regardless of whether you are rehired as a non-Pension Eligible Employee or previously were hired as a Pension Eligible Employee, if you are/were receiving your benefits in the form of an annuity at the time of your return to employment, your annuity payments will be (or were) suspended. The unpaid portion of your prior benefit will be (or was) treated as follows:

- If you are or were rehired as a non-Pension Eligible Employee, on your subsequent Benefit Commencement Date, your benefit (if any) will be reduced by the amount of annuity benefits you received. For purposes of calculating your Pay Credits (described earlier), you are <u>not</u> credited with Point Service for your period of absence or for your period of reemployment.
- If you were rehired as a Pension Eligible Employee, the unpaid portion of your prior benefit was converted to an AB II Benefit Opening Balance as of the date of your reemployment. On your subsequent Benefit Commencement Date, your Protected Benefit (if any) will be reduced by the amount of annuity benefits you received. For purposes of calculating your Pay Credits (described earlier), you are credited with Point Service both before and after your absence from employment.

In either case, your prior Service (as well as your Service earned after your reemployment) counts for vesting purposes. Note that the suspension of benefits and any conversion to an Opening Balance may be impacted if you return to work after your Normal Retirement Age and you return to employment working less than 40 hours per month. In such instances, contact the NiSource Human Resource Benefits Department for additional details regarding the effect of reemployment on your retirement benefit.

Transfers Within the Plan

If you are a Pension Eligible Employee who is participating in the AB II Benefit (see "Eligibility and Enrollment" section earlier in this Summary) and you transfer between employment positions with the Company that are both covered under the Plan (*e.g.*, non-exempt to exempt (or vice versa); union to non-union (or vice versa); or between exempt, non-exempt, or union positions with different divisions covered under the Plan), you will continue to participate in the AB II Benefit after your transfer, subject to the exception in the following sentence. If you were

hired or rehired as a Pension Eligible Employee in either a *non-exempt* position or a *union* position on or after January 1, 2010, and then transferred to an *exempt* position on or after January 1, 2010, you will no longer be a Pension Eligible Employee on and after the date of your transfer. If you fall into this category, any additional accruals to your AB II Benefit Account will cease as of the date of transfer, but you will continue to earn Interest Credits until you commence distribution of your benefit and your service following transfer shall be counted solely for purposes of vesting and determining eligibility for an early retirement benefit under the Plan (*i.e.*, for your Protected Benefit, if applicable).

If you were not a Pension Eligible Employee at your hire date, you will not become a Pension Eligible Employee through a transfer within the Plan.

Transfers to/from Affiliates

From an Affiliate

The following chart generally describes the impact on your pension benefit if you transfer *from* a particular employment position providing coverage under an affiliate's pension plan *to* an employment position with the Company that is otherwise considered a Pension Eligible Employee position providing coverage under the Plan (see "Eligibility and Enrollment" found earlier in this Summary). Unless specific provisions in the Plan or an affiliate's plan provide otherwise, your benefit will be determined as set forth below. See the NiSource Human Resource Benefits Department for further information.

<table>
<tr><th>If you transfer from an affiliate in the following position:</th><th>to the Company in the following position:</th><th>The impact on plan benefits will be as follows:*</th></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Non-union
(exempt or non-exempt)</td><td>You will remain in the affiliate's plan and will accrue no benefit under the Plan. In accordance with the terms of the affiliate's plan, you will remain subject to your plan benefit terms in effect prior to your transfer.</td></tr>
<tr><td>Union</td><td>Non-union
(exempt or non-exempt)</td><td rowspan="3">Your benefit under the affiliate's plan will be frozen as of your transfer date and you will begin to participate in the AB II Benefit of the Plan. Your prior benefit will remain in the affiliate's plan and you will begin participation in this Plan with a $0 Opening Balance. You will receive credit for Vesting Service and Point Service for your Service both before and after the transfer. With respect to your benefit under the affiliate's plan, you generally will cease to earn service for benefit accrual as of the date of transfer. However, service following transfer shall be counted for purposes of vesting and determining eligibility for an early retirement benefit under such plan.</td></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Union</td></tr>
<tr><td>Union</td><td>Union</td></tr>
</table>

*With respect to the above chart, please note the following exception: In order to accrue a benefit after a transfer to the Company (whether accruing under the affiliate's plan or the Plan), you must be a Pension Eligible Employee as described under "Eligibility and Enrollment." Thus, you will continue to accrue a benefit only if your most recent hire date with the affiliate is prior to the hire/rehire date needed to be considered a Pension Eligible Employee under the Plan (i.e., prior to January 1, 2010 for transfers to an exempt position or prior to January 1, 2013 for transfers to a non-exempt or union position). For example, if you were hired/rehired in a non-exempt position with an affiliate on or after January 1, 2010 and participate in the affiliate's plan, and then you transfer to an exempt position with the Company, you will not be considered a Pension Eligible Employee and will not participate in the Plan (or the affiliate's plan). If you are actively accruing a benefit in the affiliate's plan and after your transfer you are not considered a Pension Eligible Employee, your benefit will be frozen as of the date of transfer.

Note also that if an employee is not considered a "Pension Eligible Employee" under an affiliate's plan and he/she transfers to the Company, the employee will not become a Pension Eligible Employee through a transfer to the Plan.

To an Affiliate

The following chart generally describes the impact on your pension benefit if you are a Pension Eligible Employee and you transfer *from* a particular employment position providing coverage under the AB II Benefit of the Plan *to* an

employment position with an affiliate that does not sponsor the Plan (because the affiliate offers a different plan or no plan). Unless specific provisions in the Plan or an affiliate's plan provide otherwise, your benefit will be determined as set forth below. See the NiSource Human Resource Benefits Department for further information.

<table>
<tr><th>If you transfer from the Company in the following position:</th><th>to an affiliate in the following position:</th><th>The impact on plan benefits will be as follows:*</th></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Non-union
(exempt or non-exempt)</td><td>You will remain in the AB II Benefit of the Plan and will continue to earn Vesting Service and Point Service under the Plan after the transfer.</td></tr>
<tr><td>Union</td><td>Non-union
(exempt or non-exempt)</td><td rowspan="3">Your AB II Benefit Account in the Plan will be frozen as of the date of your transfer, but will continue to earn Interest Credits until you commence distribution of your benefit. With respect to your benefit under the Plan, you generally will cease to earn service for benefit accrual as of the date of transfer. However, service following transfer shall be counted for purposes of vesting and determining eligibility for an early retirement benefit under the Plan (i.e., for your Protected Benefit, if applicable). You will begin participating in the affiliate’s plan as a new participant (assuming you are classified as a "Pension Eligible Employee" under that plan). If the affiliate’s plan provides for your participation in an AB I or AB II Benefit option, you shall begin participation in such option with a $0 opening balance, though you will receive credit for vesting service and point service both before and after the transfer.</td></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Union</td></tr>
<tr><td>Union</td><td>Union</td></tr>
<tr><td>Union</td><td>NiSource Corporate Services</td><td rowspan="2">You will remain in the AB II Benefit of the Plan and will continue to earn Vesting Service and Point Service under the Plan after the transfer.</td></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>NiSource Corporate Services</td></tr>
</table>

*With respect to the above chart, please note the following exception: If you transfer to a position with an affiliate that does not consider you to be a "Pension Eligible Employee" under the affiliate's plan (due to your most recent hire date with the Company), you will not be eligible to participate in the affiliate's plan nor continue to participate in the Plan. Thus, for example, if you were hired or rehired as a Pension Eligible Employee in a non-exempt position under the Plan on or after January 1, 2010, and then transfer to an exempt position with an affiliate, you will no longer be a Pension Eligible Employee under the Plan or the affiliate's plan on and after the date of your transfer. If you are actively accruing a benefit in the Plan, that benefit will be frozen as of the date of transfer, but will continue to earn Interest Credits until you commence distribution of your benefit and your service following transfer shall be counted solely for purposes of vesting and determining eligibility for an early retirement benefit under the Plan.

If you are a Pension Eligible Employee and transfer from employment providing coverage under the Plan to a union or a non-union position with an affiliate that does sponsor the Plan, then you will remain in the AB II Benefit of the Plan (assuming you continue to be considered a Pension Eligible Employee).

If You Continue to Work After Normal Retirement Age

If you choose to work beyond your Normal Retirement Age, you will continue to earn Pay Credits and Interest Credits until you retire. If you work 40 or more hours per month on and after reaching Normal Retirement Age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching Normal Retirement Age, you may begin receiving your pension benefit from the Plan.

If You Become Disabled

If you become Disabled while working for the Company, the calculation of your Plan benefit will be impacted as described in this section. In general, “**Disability**” or “**Disabled**” under the Plan means any physical or mental condition that constitutes a disability under the long-term disability plan (the “LTD Plan”) maintained by the

Company. A Disability commences when you first qualify for benefits under the Company's LTD Plan and ceases when you no longer qualify for benefits under such LTD Plan.

If you are considered Disabled under the Plan and later return to active employment as a Pension Eligible Employee, you will continue to be covered under the AB II Benefit once you return to active work. Note that if not already considered an AB II Participant, any Disabled Pension Eligible Employee became an AB II Participant (effective as of January 1, 2012 for any exempt Pension Eligible Employee and effective as of January 1, 2013 for any non-exempt or union Pension Eligible Employee). Note that you will only continue to accrue benefits under the Plan if prior to the commencement of your Disability you were a Pension Eligible Employee and you remain a Pension Eligible Employee after your return to active employment.

Service Crediting. If you are considered Disabled under the Plan, you will continue to earn Vesting Service and Point Service while the Disability continues without regard to whether the Disability lasts beyond one year and could thus constitute a "Severance from Service" (as defined in the Plan). Point Service under the Disability provision shall cease to be credited as of the earliest of (1) the date on which your Disability ends pursuant to the Company LTD Plan (which shall be deemed your "Termination of Service" (as defined in the Plan) unless you return to employment with the Company or unless the Company determines a different "Termination of Service" date), (2) the date on which you return to employment, or (3) the date your benefit under the Plan commences. Note that if your Disability under the Company LTD Plan commenced prior to January 1, 2000, you earned Point Service during the period of your Disability prior to January 1, 2000 only if you were both Disabled under the Plan and eligible for disability benefits under the Social Security Act.

Your Account. You will continue to receive Pay Credits and Interest Credits to your Account while you are Disabled. For these purposes, you will be deemed to receive Eligible Pay at the same level of Eligible Pay in effect for the month when you became Disabled (but excluding any performance-based components of Eligible Pay). See the "How the Plan Works" section earlier this summary for an explanation of what compensation counts as Eligible Pay.

You may elect to start your Plan benefit payments at any time once you are considered to have terminated employment by the Company. You may receive your benefit under any of the payment options described in "Payment Options Under the Plan" above. Note that if you elect to begin benefit payments, you will stop earning Pay Credits and Interest Credits. In addition, commencing your Plan benefit might mean that your LTD benefits would no longer be payable. For more information about electing payment of your Plan benefit and whether such an election would impact your LTD payments, contact the Benefits Center at 1-888-640-3320 and consult your LTD Plan.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

As stated above, to request your Plan benefits you must obtain a pension benefit commencement kit from the Benefits Center (1-888-640-3320; www.mysourceforhr.com).

Claim Denial and Appeal Process

If you disagree with any decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the administrative review procedure you must follow. If you think benefits owed to you are not paid, or are too low, or are paid at a time other than when you think they should be, you can make a "claim" for benefits to the Plan Administrator.

If your claim for a pension benefit is denied in whole or in part, you have the right to request a review of the denial. You (or your beneficiary) will be notified of a denial of your claim in writing by the Plan Administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice of the denial will include:

- The specific reason(s) for the denial;
- Specific reference to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan Administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the NiSource Benefits Committee at the following address:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Notwithstanding the foregoing, if the NiSource Benefits Committee's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the final determination may be made within the period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii) in lieu of the 60-day period (120-day period if extended due to special circumstances) described above.

If your appeal is denied, you will be told why and which Plan provisions support that decision. If the final determination is made in your favor, the determination shall be binding and conclusive. If the final determination is not made in your favor, the determination shall be binding and conclusive unless you notify the NiSource Benefits Committee within 90 days after the mailing or delivery of the determination that you intend to institute legal proceedings under Section 502(a) of ERISA challenging the determination, and you actually institute such legal proceedings within 180 days after such mailing or delivery. All questions arising with respect to the Plan during any such legal proceedings shall be governed by Indiana law, except to the extent superseded by federal law.

TAX CONSEQUENCES

How and When Your Plan Benefits are Taxed

Generally, federal and state income tax laws do not require you to pay tax on your Plan benefits until you actually receive distributions under the Plan. Once you begin to receive benefit payments, you will have taxable income on these payments in the year that you receive them. In the year(s) of any distribution from the Plan, you will receive a tax form that will provide you with the information you need to file your taxes. You may be able to defer federal income taxes and avoid any penalty taxes if you transfer or "roll over" your distribution (see the Rollover section below). You should consult your tax advisor concerning any distribution you receive from the Plan.

Withholding Requirements

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA, including a Roth IRA (see the Rollover section below). You should consult with your personal tax adviser regarding this matter.

Rollovers

If you receive your benefit under the plan in the form of a single lump-sum, you may elect to roll over all or a portion of the distribution to an Individual Retirement Account/Annuity (an "IRA") or into another retirement plan that accepts rollovers from qualified plans. If you directly roll over your distribution from the Plan into a traditional IRA or another retirement plan, no income tax will be due on the amount rolled over and earnings thereon until you begin withdrawing the funds from the traditional IRA or retirement plan. If you roll over your distribution to a Roth IRA, the amount rolled over *is* subject to income tax in the year of the rollover. Under certain circumstances, all or a portion of a distribution may not qualify for rollover treatment.

As stated above, if you elect to have your benefit paid directly to you in a lump-sum payment, rather than rolled over, 20% of your distribution will be withheld and paid to the IRS. Even if you elect to have your benefit paid directly to you, you may still decide to roll over all or a portion of your distribution to an IRA or another retirement plan. If you decide to roll over your distribution, you must make the rollover within 60 days after you receive the distribution. If you choose to roll over 100% of your distribution, you must replace the 20% that has been withheld with other money available to you within the 60-day period. If you do not replace the 20% that has been withheld and you roll over only the 80% that you actually received, you will be taxed on the 20% that was withheld.

Note that in contrast to a single lump-sum payment, you cannot roll over monthly benefit payments into an IRA or another retirement plan.

Distributions Prior to Age 59 ½

In addition to being taxed as ordinary income, the taxable portion of a distribution taken prior to age 59 ½ (an early distribution) may be subject to a nondeductible federal penalty tax of 10%. Additional penalties may exist under state tax law. Early distributions are exempt from federal penalty taxes if the distribution was made for one of the following reasons:

- Distribution to your named beneficiary due to your death;

- Distribution that is made in the form of annuity payments over your life expectancy or over the life expectancy of you and your beneficiary;
- Distribution is made after termination of employment if you terminate after you reach age 55;
- Distribution that is made because you are totally and permanently disabled;
- For deductible medical expenses;
- Payment to an alternate payee under a qualified domestic relations order upon dissolution of a marriage; or
- To roll over to an IRA or other retirement plan within 60 days of receipt.

Please contact your Plan Administrator to receive a copy of the Special Tax Notice regarding payments from the Plan. This notice contains important information that you need to know before making a payment/withholding election.

AMENDMENT OR PLAN TERMINATION

The Committee expects to continue the Plan, but reserves the right to suspend, amend, modify, or terminate the Plan in whole or in part at any time. If the Plan is amended, the amendments will not decrease your Accrued Benefit as of the time an amendment is adopted.

The Committee may only amend the Plan in writing. Any amendment shall be duly authorized if approved or ratified by the Committee. Thus, the Plan may not be modified or amended simply by representations, oral or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or human resources representative, for instance. If you believe you have received information that is contrary to the terms of the Plan or this Summary, please contact the Plan Administrator for clarification or confirmation.

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be fully vested as of the date of the termination. Benefits will be paid, according to law, as described in the following paragraph. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan assets would be used to pay benefits to retirees, beneficiaries, and active participants, up to the total amount of assets in the Plan's trust. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made in the following order of priority: (1) benefits that are being paid or that will begin to be paid within three years; (2) benefits guaranteed by the Pension Benefit Guaranty Corporation; (3) benefits that were already vested before the Plan's termination; and (4) all other benefits.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Your Benefits are Insured

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and

- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the Benefits Center at **1-888-640-3320** or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

ADMINISTRATIVE / LEGAL OVERVIEW

Administrative Information

Plan Sponsor

The Plan Sponsor is NiSource Inc.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee (the "Committee"). In its discretion, the Committee may designate members of the NiSource Human Resources Department or other individuals to act on its behalf with respect to the administration of the Plan. The Committee has the sole authority to interpret the terms of the Plan. You may contact the Committee/Plan Administrator at:

NiSource Inc.
Attn: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-4334

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for NiSource Inc. is 35-2108964.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 001. The AB II Benefit is a cash balance plan. The official Plan name is the Columbia Energy Group Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan Trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Committee's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the Plan Trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Legal Information/Issues

Employment Rights

The Plan is neither a contract for employment nor consideration for employment. Participation in the Plan is not a guarantee of or contract for new or continued employment. All employees remain subject to termination, layoff, or discipline as if the Plan had never been put into effect.

If the Plan Becomes "Top-Heavy"; A Legal Limitation

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $175,000 (indexed for 2018), and employees who are 1 percent owners of the Company with annual compensation of more than $150,000 (not indexed), 5 percent owners of the Company, and beneficiaries of the above. You will be notified if this affects you.

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Manager, Benefits Accounting & Compliance
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan Administrator or the Plan Trustee.

Governing Law and Venue

Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law. Any suit, action, or proceeding related to the Plan or benefits under the Plan shall be brought in any court of the State of Indiana and of the United States for the Northern District of Indiana.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

Collective Bargaining Agreements

As stated earlier in this SPD, employees who are covered by a collective bargaining agreement are not eligible for the Plan unless the applicable collective bargaining agreement provides for participation in the Plan. For those employees who are covered by a collective bargaining agreement providing for participation in the Plan, the Plan is maintained pursuant to a collective bargaining agreement.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged, or garnished, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend, or a court-appointed guardian.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (Social Security retirement age) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension 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 your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.
- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), 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 NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the "Publications Hotline" of the EBSA.

OUTSIDE BACK COVER

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NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Non-Exempt, Non-Union, Part-Time Employees Hired or Rehired Before January 1, 2013

Contents

Page

Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular part-time non-exempt, non-union employees hired or rehired before January 1, 2013 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 102.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – Pension and 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement

under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program**

Overview and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Safety Plan Rehire" means (i) a person eligible for retiree medical and retiree life insurance benefits who is rehired by Columbia Gas of Ohio, Inc. after January 1, 2019 to support the construction activities associated with regulator station replacement in conjunction with the LP-Enhanced Safety Plan and natural gas system replacement projects, or (ii) a retiree who was rehired by Bay State Gas Company after January 1, 2019 for a short-term position as Department of Public Utilities liaison for the third-party audit of post-incident construction.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note: It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be

denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues, and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether*

you are eligible to participate in the Medical, Dental or Vision Plan.

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year, you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months prior to the month in which you apply for benefits, but not earlier than the first month you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits*

*Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular part-time employee of a Participating Employer, (ii) regularly work less than 40 hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, and vision coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO coverage under the Medical Plan), basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

> **Please Note:**
>
> Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you

may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (collectively referred to as "Employee Life and AD&D Insurance").

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a

participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your child(ren) under the same plan. Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Special Rule for Rehired Employees

If you terminate employment and are rehired after your termination date, the benefit elections that were in effect on the date of your termination **will not be** automatically reinstated. You will need to re-elect coverages once you again become eligible upon your return.

Upon your rehire, you will be no longer be entitled to benefits under Active Benefit Program 102, but will instead designated as being entitled to the Active Benefit Program applicable to similarly situated eligible employees hired as of the date of your rehire. In addition, unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , as a rehired employee, you will not be entitled to any retiree medical or retiree life insurance benefits upon your retirement or other termination of employment.

Special Rule for Certain Employment Transfers

If you were hired or rehired on or after January 1, 2010, and you thereafter transfer to an "exempt employee" status, you will not be eligible for retiree medical or retiree life insurance benefits upon your retirement or other termination of employment. An "exempt employee" includes a non-union employee (an employee whose employment is not subject to the terms of a collective bargaining agreement) and an employee who is not entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. §201, et seq.

This special rule does not apply to a Safety Plan Rehire, to the extent such Safety Plan Rehire is not thereafter rehired by an Employer or transferred to another employee status.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates. You will be advised of any new benefit plans,

plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;

- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage"* for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;
- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day.

If you are not actively at work on the date coverage would otherwise begin, you will not be eligible for the coverage until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Coverage Ends

Your Employee Life and AD&D Insurance will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D Coverage Option, the date such Life and AD&D Coverage Option is terminated;
- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular part-time employee or as a member of another eligible class;

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active part-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, or the Flexible Benefits Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all

requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical

Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***

- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

In the case of a divorce or separation, the following order will establish responsibility for payment:

- If there is a court order that requires a parent to take financial responsibility for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.
- The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.
- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.
- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-

eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits, the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse

benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the

circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;
- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your

receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to

request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;

- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective

review, were covered under the Plan at the time the health care item or service was provided;

- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the

criteria are inconsistent with the terms of the Plan or with applicable law;

- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has

not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

- Your name;
- The date(s) of the medical service;
- The specific medical condition or symptom;
- The provider's name
- The service or supply for which approval of benefits was sought; and

- Any reasons why the appeal should be processed on a more expedited basis.

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or

comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to

contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request

for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D

Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a

claim and an explanation of why such information is necessary, and

- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a

notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its

discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan. Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." The leaves referred to above are:

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account

of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage

does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care FSA, you may continue your current contributions to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another

qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to provide any group health plan or coverage to any employee.
- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under

ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at dol.gov/ebsa (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);

- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you

use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice

President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may

have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Benefit Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Benefit Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Benefit Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is

denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Medical Coverage for Retirees

You may be eligible for medical benefits as a retired employee if you meet certain eligibility requirements. For further information about your eligibility for medical benefits as a retired employee or to notify the Company or your Employer of your retirement, contact the Benefits Source at **1-888-640-3320**.

Unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , if you retire or otherwise terminate employment and are later rehired by the Company, a Participating Employer, or any of their affiliates, you will not be eligible for retiree medical or retiree life insurance benefits, including after your subsequent retirement or other termination of employment.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan

benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible†	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

†Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	Out-of-Network
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	Out-of-Network
	Plan Pays	Plan Pays
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$3,000	$6,000	$5,000	$10,000

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at 1-888-640-3320 for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

TYPE OF SERVICE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

TYPE OF SERVICE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers,

distributors, and/or similar vendors, which may be related to certain prescription drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 29.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and

  - Prescribed medications (Outpatient prescription drug services are covered under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).
- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;

  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam and one hearing aid per ear during a two calendar-year period; and
- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational

therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;
- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance,

when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

  See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age,

gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

  See the following website for additional information:
  https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;

- Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);
- Screening for gestational diabetes;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

  - Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

  - Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
  - Inpatient covered hospital services related to the transplant procedure.
  - Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

***Please Note**:* Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	Plan Pays		Plan Pays		Plan Pays	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 35.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:
  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 35.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network

schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA FEATURES	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. A non-exhaustive list of eligible expenses can be found later in this section.
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). A non-exhaustive list of eligible expenses can be found later in this section.

FSA FEATURES	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at 1-888-640-3320 for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 35.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - — Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - — Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting

from an accident or trauma, or disfiguring disease;

- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may

receive from a special course of study and disciplinary methods;

- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and

— Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - — Nursery school;
  - — Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 36.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax*

purposes. Please consult your tax advisor for more information.

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out

of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Life and AD&D Plan

Employee Term Life Coverage – Basic Plan

Employee AD&D Coverage – Basic Plan

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at* ***1-888-640-3320****.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in the amount of $20,000.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor. The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Payment of Death Benefits under Life Coverage

If you die while covered under the Plan, the amount of insurance on you is payable when Securian's home office receives written proof satisfactory to it that you died while covered under the Plan and insured under the Group Insurance Certificate. If you die within 31 days after ceasing to be covered under the Plan, but while you are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features*" below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in the amount of $20,000.

Additional AD&D Coverage

The Plan provides additional benefits under the Basic AD&D Coverage Option for your loss of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including

Reserve or National Guard active duty for training); (8) travel in or descent from any aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance, except that you may convert the amount of insurance under the Employee Term Life Insurance that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You are eligible to continue your Employee Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by

Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at ***1-888-640-3320****, or online via the Benefits Source website at* mysourceforhr.com*. If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Non-Exempt, Non-Union, Full-Time Employees Hired or Rehired Before January 1, 2013

Contents

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular full-time non-exempt, non-union employees hired or rehired before January 1, 2013 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 101.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Travel Accident Coverage (NiSource Travel Accident Plan – referred to as the "Travel Accident Plan")
- Short-Term Disability Coverage (NiSource Short-Term Disability Plan –

referred to as the "Short-Term Disability Plan")

- Long-Term Disability Coverage (NiSource Long-Term Disability Plan – referred to as the "Long-Term Disability Plan")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – Pension and 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the

applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a

person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview** and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Safety Plan Rehire" means (i) a person eligible for retiree medical and retiree life insurance benefits who is rehired by Columbia Gas of Ohio, Inc. after January 1, 2019 to support the construction activities associated with regulator station replacement in conjunction with the LP-Enhanced Safety Plan and natural gas system replacement projects, or (ii) a retiree who was rehired by Bay State Gas Company after January 1, 2019 for a short-term position as Department of Public Utilities liaison for the third-party audit of post-incident construction.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note: It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a

Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues; and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under

a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Medical, Dental or Vision Plan.*

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year, you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months

prior to the month in which you apply for benefits, but not earlier than the first month you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Travel Accident Plan

If you are classified as a full-time employee, you will be eligible to participate in the Travel Accident Plan as of your first day of active, full-time employment with a Participating Employer. You are a "full-time employee" if you are characterized by your Employer as a full-time employee who regularly works 40 or more hours per week.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Travel Accident Plan.*

Eligibility under the Short-Term Disability Plan

If you are a full-time employee, you will be covered under the Short-Term Disability Plan as of the first day of the month coincident with or next following your completion of six continuous months of active, full-time employment with a Participating Employer. You are a "full-time employee" if you are characterized by your Employer as a full-time employee who regularly works 40 hours per week. Newly hired employees must be actively at work on the date coverage is scheduled to begin.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Short-Term Disability Plan.*

Eligibility under the Long-Term Disability Plan

You are eligible to participate in the Long-Term Disability Plan if you are a regular full-time employee of a Participating Employer who works 40 or more hours per week and are in active employment. You are in active employment if you are working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. Your worksite must be your Employer's usual place of business, an alternate work site at the direction of your Employer other than your home, unless clear specific expectations and duties are documented, or a location to which your job requires you to travel. Your eligibility for optional, contributory coverage may be subject to your satisfying other requirements established by Prudential Insurance Company of America. Refer to the group insurance certificate issued by Prudential for more details.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Long-Term Disability Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular full-time employee of a Participating Employer, (ii) regularly work 40 or more hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued

if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

Your eligibility for optional, contributory coverage may be subject to your providing evidence of insurability and satisfying other requirements established by the insurer, Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc.

See the Life and AD&D Benefit Plan section below and refer to the group insurance certificate issued by Securian for further details.

Eligible Dependents

If you are eligible to participate in the Life and AD&D Plan, you may obtain certain coverage for your "eligible dependents." Your "eligible dependents" are:

- Your lawful Spouse, provided you are not legally separated; and
- Your unmarried children from live birth to the end of the month in which the unmarried child attains age 26; and

Your "children" include: (1) your natural children, legally adopted children and children placed with you for adoption prior to legal adoption; and (2) each of your stepchildren, foster children, children subject to legal guardianship, grandchildren, and other children who are blood relatives who depend on you for more than fifty percent of their support and maintenance. A child placed with you for adoption prior to legal adoption is considered an eligible dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

Notwithstanding the foregoing, your unmarried children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on you for more than 50% of their support and maintenance.

Also notwithstanding the foregoing,

(1) Your spouse is not your "eligible dependent" while on active duty in the armed forces of any country; and

(2) Your child is not your "eligible dependent" while (a) on active duty in the armed forces of any country; or (b) insured under any Employee Insurance.

A child will not be considered the "eligible dependent" of more than one employee. If this would otherwise be the case, the child will be considered the "eligible dependent" of the employee named in a written agreement of all such employees filed with the Company. If there is no written agreement, the child will be considered the "eligible dependent" of:

(1) the employee who became insured under the Plan with respect to the child while the child was an "eligible dependent" of only that employee; and otherwise

(2) the employee who has the longest continuous service with a Participating Employer, based on the Company's records.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits Source at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Life and AD&D Plan.*

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, vision, supplemental and dependent life and AD&D and supplemental long-term disability coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO coverage under the Medical Plan), travel accident, short-term disability, basic long-term disability, basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.** To enroll in supplemental and dependent life and AD&D and supplemental long-term disability coverages, you must use enrollment forms approved by Securian (with respect to life and AD&D coverage) and Prudential (with respect to long-term disability coverage). You may obtain these enrollment forms by contacting the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

Please Note:

Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect

for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Travel Accident Plan

No affirmative enrollment is required for the Travel Accident Plan. You are automatically enrolled upon the date you become eligible for such coverage.

Enrollment in the Short-Term Disability Plan

No affirmative enrollment is required for the Short-Term Disability Plan. You are automatically enrolled upon the date you become eligible for such coverage.

Enrollment in the Long-Term Disability Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Long-Term Disability Plan*" section above, you will be automatically enrolled in the Basic LTD Coverage Option, unless you choose to enroll in the Supplemental LTD Coverage Option. Newly eligible employees must enroll in the Supplemental LTD Coverage Option within 31 days of their date of hire or, if later, the date they first become eligible for coverage. If you fail to enroll, you will automatically be covered under the Basic LTD Coverage Option. In general, once you enroll in (or decline) the Supplemental LTD Coverage Option, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.)

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (such Life and AD&D Coverage Options, together with the Optional Employee Term Life Coverage Option and the Supplemental Employee AD&D Coverage Option, are collectively referred to as "Employee Life and AD&D Insurance"). If you desire coverage under the Optional Employee Term Life Coverage Option, the Dependents Term Life Coverage Option, the Supplemental Employee AD&D Coverage Option, or the Dependents AD&D Coverage Option (collectively the "Optional Life and AD&D Coverage Options") as a newly eligible employee, you must enroll in such Optional Life and AD&D Coverage Option within 31 days of your date of hire or the

date you become newly eligible. If you do not enroll in an Optional Life and AD&D Coverage Option during this initial 31-day period, you may need to provide evidence of insurability if you decide to enroll at a later date. You must enroll using forms approved by Securian. *You may obtain forms for enrolling in, or changing, your Optional Life and AD&D Coverage Options by contacting the Benefits Source at* ***1-888-640-3320.***

In general, once you enroll in (or decline) any of the Optional Life and AD&D Coverage Options, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage election will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.) If any change in coverage is subject to evidence of insurability, Securian must decide that such evidence is satisfactory.

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your child(ren) under the same plan (e.g., child life insurance). Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Special Rule for Rehired Employees

If you terminate employment and are rehired after your termination date, the benefit elections that were in effect on the date of your termination **will not be** automatically

reinstated. You will need to re-elect coverages once you again become eligible upon your return.

Upon your rehire, you will no longer be entitled to benefits under Active Benefit Program 101, but will instead be designated as being entitled to the Active Benefit Program applicable to similarly situated eligible employees hired as of the date of your rehire. In addition, unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , as a rehired employee, you will not be entitled to any retiree medical or retiree life insurance benefits upon your retirement or other termination of employment.

Special Rule for Certain Employment Transfers

If you were hired or rehired on or after January 1, 2010, and you thereafter transfer to an "exempt employee" status, you will not be eligible for retiree medical or retiree life insurance benefits upon your retirement or other termination of employment. An "exempt employee" includes a non-union employee (an employee whose employment is not subject to the terms of a collective bargaining agreement) and an employee who is not entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. §201, et seq.

This special rule does not apply to a Safety Plan Rehire, to the extent such Safety Plan Rehire is not thereafter rehired by an Employer or transferred to another employee status.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates. You will be advised of any new benefit plans, plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

Opt-Out Credit

If you are a full-time employee and have coverage elsewhere and decline medical or dental coverage under the Medical or Dental Plans, you may be eligible for an opt-out credit, if available. Please refer to the enrollment material to see if this option is currently being offered. If you have declined coverage, but your Spouse or parent is also an employee or retiree and is covering you as a dependent, you are not entitled to an opt-out credit. If you are a covered dependent under the Medical and/or Dental Plans, you must call the Benefits Source at **1-888-640-3320** during enrollment to update your status. The Company will recover payment of ineligible opt-out credits through payroll deductions.

Please Note:

If you have declined Medical Plan coverage, but your Spouse or parent is also an employee or retiree who is covering you under the Medical Plan as a dependent, you are not entitled to an opt-out credit. You must call the Benefits Source at **1-888-640-3320** during enrollment to update your status.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage*" for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided

under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;

- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Travel Accident Plan

Coverage Begins

Your Travel Accident Plan coverage becomes effective on the first day of your active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Travel Accident Plan for benefits on the earliest of the following:

- The date as of which the Plan is terminated;
- The date that the Plan is amended to terminate your coverage;
- The date you are no longer eligible for coverage under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy; and
- The date you terminate employment.

When Coverage Begins and Ends – Short-Term Disability Plan

Coverage Begins

Your Short-Term Disability Plan coverage became effective on the first day of the month coincident with or next following the date you completed six continuous months of active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Short-Term Disability Plan for benefits on the earliest of the following:

- The date the Plan is terminated;

- The effective date of any Plan amendment that terminates coverage with respect to you;
- The date you are no longer eligible for coverage under the Plan, including without limitation as a result of your Employer no longer being affiliated with the Company or no longer being a Participating Employer in the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994;
- The last day for which you made any required contribution toward the cost of Plan coverage;
- The date you begin any leave of absence; and
- The date your employment terminates.

When Coverage Begins and Ends – Long-Term Disability Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Long-Term Disability Plan,"* coverage under the Basic LTD Coverage Option of the Long-Term Disability Plan generally may become effective on the later of (1) your first day of active employment, for regular new hires, (2) the day you become a member of a class eligible for coverage under the Plan, (3) the first day of the following Plan Year, for eligible employees who choose not to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period, or (4) the date the Plan approves such enrollment, for employees who disenroll from the Supplemental LTD Coverage Option due to a qualified life event.

Coverage under the Supplemental LTD Coverage Option generally may become effective on the later of (1) the date you are eligible for coverage, if you enroll on or before that date; (2) the date you enroll for coverage, if you enroll within 31 days after the date you are eligible for coverage; (3) the date Prudential approves your application, if evidence of insurability is required; (4) the date you are in active employment; (5) the first day of the following Plan Year, for eligible employees who choose to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period; or (6) the date the Plan approves such enrollment due to a qualified life event.

Evidence of insurability means a statement of your medical history that Prudential will use to determine if you are approved for coverage. You must give evidence of insurability, at your expense, if (1) you enroll for coverage more than 31 days after the date you are eligible for it; (2) you re-enroll for coverage after you voluntarily cancelled it; (3) you enroll after any coverage ends because you did not pay a required contribution; or (4) you have not met a previous evidence requirement to become covered under any plan NiSource has with Prudential. Prudential will decide when evidence of insurability is satisfactory.

Once your coverage begins, any increased or additional coverage will take effect on the latest of: (1) the effective date of the change, if you are in active employment, on a temporary layoff, on leave of absence, or working reduced hours (for reasons other than disability); (2) the date Prudential approves your application, if evidence of insurability is required; or (3) the date you return to active employment, if you are not in active employment due to injury or sickness.

Coverage Ends

Your coverage under the Long-Term Disability Plan will end on the date you lose eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the group insurance contract issued by The Prudential Insurance Company of America is canceled;
- The date that the Plan is amended to terminate your coverage;

- The date you terminate employment or are no longer eligible for coverage under the Plan;
- The date you are no longer in active employment due to a disability that is not covered under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made; or
- The date you are no longer in active employment, except as provided below and except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 ("FMLA").

If you are on a temporary layoff or are working reduced hours for reasons other than disability and the premium is paid, you will be covered to the end of the month following the month in which your temporary layoff or reduced hours begin. If you are on a leave of absence and the premium is paid, you will be covered to the end of the month in which your leave begins. Neither temporary layoff nor leave of absence includes normal vacation time or any period of disability or absence in connection with any severance or termination agreement. Your FMLA leave also is not considered a temporary layoff.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day.

Provided you have satisfied the eligibility requirements described above, coverage under the Employee Optional Life and AD&D Coverage Options may generally become effective on the first day on which each of the following conditions are met: (1) you have enrolled for coverage, including, if required, applying for coverage on forms approved by the Claims Administrator, (2) with respect to the Optional Employee Term Life Coverage Option, the Claims Administrator is satisfied with your evidence of insurability, if evidence is required (provided that coverage will become effective as of the first day of the month following the Claims Administrator's determination that evidence is satisfactory), and (3) the Claims Administrator has received the required premium.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Provided you have satisfied the eligibility requirements described above, coverage of your "eligible dependents" under the Dependents Term Life Coverage Option and the Dependents AD&D Coverage Option ("Dependents Life and AD&D Insurance") generally may become effective on the first day on which each of the following conditions are met: (1) you have enrolled for dependent coverage, including, if required, applying for coverage on forms approved by the Claims Administrator, (2) the person to be covered is your "eligible dependent", (3) you are insured for employee coverage under the particular coverage sought (e.g., for the Dependents Term Life Coverage Option, you are covered under the Basic Employee Term

Life Coverage Option, and for the Dependents AD&D Coverage Option, you are covered under the Supplemental Employee AD&D Coverage Option), (4) for the Dependents Term Life Coverage Option, the Claims Administrator is satisfied with your eligible dependent's evidence of insurability, if evidence is required, and (5) the Claims Administrator has received the required premium.

If an eligible dependent (other than a newborn child) is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement.

Evidence of your insurability may be required under certain circumstances if you apply for coverage under the Optional Employee Term Life Coverage Option. Evidence of your eligible dependent's insurability may also be required under certain circumstances if you apply for coverage for your eligible dependent under the Dependents Term Life Coverage Option. See the sections in the Life and AD&D Benefits Plan section below entitled *"Optional Employee Term Life Coverage"* and *"Dependents Term Life Coverage"* for more details concerning evidence of insurability requirements.

If you apply for coverage that requires evidence of insurability, your coverage election will be autocorrected to the greatest amount of coverage, consistent with your election, to which you would otherwise be entitled without evidence of insurability. Once evidence of insurability is approved by Securian, your coverage will be updated effective the first of the month following approval (or, if later, January 1, in the case of an election made during annual enrollment).

Coverage Ends

Your Employee Life and AD&D Insurance or Dependents Life and AD&D Insurance under a Life and AD&D Coverage Option will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D Coverage Option, the date such Life and AD&D Coverage Option is terminated;
- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular full-time employee or as a member of another eligible class;
- For Life and AD&D Coverage Options that are contributory, 31 days after the due date of any required contribution that is not paid, provided that failure to contribute for Dependents Life and AD&D Insurance will not cause your Employee Life and AD&D Insurance to end;
- For the Dependents Term Life Coverage Option, the date your coverage under the Basic Employee Term Life Coverage Option ends;
- For the Dependents AD&D Coverage Option, the date your coverage under the Supplemental Employee AD&D Coverage Option ends;
- For Dependents Life and AD&D Insurance, the last day of the month in which your "eligible dependent" ceases to be an "eligible dependent" for the coverage or is no longer covered under the Group Contract.
- For coverage under an Employee Optional Life and AD&D Coverage Option, the last day for which premium contributions have been made following your written request to end coverage under such Employee Optional Life and AD&D Coverage Option.
- For Dependents Life and AD&D Insurance, the last day for which premium contributions have been made following your written request to end Dependents Life and AD&D Insurance for an "eligible dependent"

You must notify the Claims Administrator or the Benefits Source at **1-888-640-3320** when a dependent is no longer eligible for

coverage under the Life and AD&D Plan so that premiums may be discontinued. No claims will be paid under the Life and AD&D Plan in respect of an ineligible dependent.

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active full-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, the Flexible Benefits Plan, the Life and AD&D Plan or the Long-Term Disability Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.

- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***
- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday

Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

In the case of a divorce or separation, the following order will establish responsibility for payment:

- If there is a court order that requires a parent to take financial responsibility for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.
- The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.
- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.
- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may

not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits, the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations.

Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;
- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that

is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any

deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider

additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim.

Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that

takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA

following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly

authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Travel Accident Plan

The claim determination and appeal process described below applies to the Travel Accident Plan. As used in this section, (i) the term "Plan" refers to the Travel Accident Plan, and (ii) the term "Claims Administrator" refers to the NiSource Benefits Department or such other claims administrator appointed for the Plan. Any claim for benefits submitted after eighteen months from the date of a covered person's death may not be considered for payment.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

Within 90 days of receiving a claim, the Claims Administrator will provide your beneficiary with a written notice of its decision. If because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator Denies the Claim

If the Claims Administrator denies your beneficiary's claim in whole or in part, your

beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the pertinent provisions in the Plan on which the denial is based;
- A description of any additional material or information necessary for your beneficiary to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals.

Appeal to Claims Administrator

If your beneficiary has a claim denied in whole or in part, your beneficiary has the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial.

Your beneficiary's request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Travel Accident Plan.

Your beneficiary may submit written comments, documents, records, and other information relating to the claim for benefits. Upon his or her request, your beneficiary will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Your beneficiary's written request should state why he or she thinks the claim should not have been denied. Your beneficiary's request also should include any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your beneficiary's request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by your beneficiary relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

Your beneficiary will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator Denies the Appeal

If the Claims Administrator denies your beneficiary's appeal in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A statement that your beneficiary is entitled to receive upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits; and

- A statement indicating the beneficiary's right to file a lawsuit upon completion of the claims procedure process.

Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your beneficiary's claim on appeal, your beneficiary may file a written claim with the Plan Administrator within 60 days after your appeal has been denied in whole or in part by the Claims Administrator.

Any claim for benefits with the Plan Administrator will be processed within 60 days of its receipt unless additional time is required to process the claim, in which event your beneficiary will be notified that an additional period of 60 days is required to process the claim. The notice will include the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision.

If the Plan Administrator Denies the Appeal

If your beneficiary's claim for benefits is denied in whole or part by the Plan Administrator, written notice of the decision to deny such application will be promptly furnished to your beneficiary within 60 days after receipt of the claim for benefits, or within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the claim. Notwithstanding the foregoing, if the Plan Administrator's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Plan Administrator's final determination may be made within the period specified in Department of Labor Regulations Section 2560.503-1(i)(ii). Each notice of denial of an application shall be in writing and shall contain the following information:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A statement that your beneficiary is entitled to receive upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claimant has exhausted all claims and appeals to the Claims Administrator and Plan Administrator. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date of the covered person's death.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Short-Term Disability Plan

The claim determination and appeal process described below applies to the Short-Term Disability Plan. As used in this section, (i) the term "Plan" refers to the Short-Term Disability Plan, (ii) the term "Claims Administrator" refers to the applicable claims administrator appointed for the Plan, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in the Plan or a rescission of your disability coverage (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) before you request a formal appeal. If you are not satisfied with a benefit determination, you can appeal it.

Consideration of the Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but generally not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding Your Claim

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or,

alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written or electronic notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- a description of the Plan's review procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following exhaustion of the claims procedure process;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits, you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 180 days of the receipt of the written adverse benefit determination.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request should also include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an

individual who is neither the person who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such person.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claims Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For claims filed after April 1, 2018, before the Claims Administrator issues and averse benefit determination on appeal, it will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person (or at the direction of the Plan or such other person) making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on appeal based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination on review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Appeal

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Claims Administrator makes an adverse benefit determination on your appeal, it will notify you of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the benefit determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- a statement indicating your right to file a lawsuit upon completion of the appeal process.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or,

alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination on your appeal, it will notify you in writing or electronically of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement indicating (A) your right to bring an action under section 502(a) of ERISA upon exhaustion of the claims procedure process, (B) that any such action must be brought no later than three years after the date an initial claim should have been filed under these claims procedures, and (C) the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Appeal to the Plan Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim on review, you or your duly authorized representative may appeal the Claims Administrator's determination by sending a written request to the Plan Administrator within 45 days of your receipt of the Claims Administrator's adverse benefit determination on review.

The Committee, as Plan Administrator, has delegated to the Director, Benefits, the Director, Corporate Insurance and the Senior Vice President and Chief Human Resources Officer, and to the officers or employees of the Company or of its affiliates succeeding to the duties and responsibilities of such persons, the authority to decide appeals of denied claims on behalf of the Plan Administrator. Such appeals shall be decided by the Director, Benefits and the Director, Corporate Insurance, or by the officers or employees of the Company or of its affiliates succeeding to the duties and responsibilities of such persons. In the event such persons do not agree on the decision with respect to an appeal, the Senior Vice President and Chief Human Resources Officer, or the officer or employee of the Company or of its affiliates succeeding to the duties and responsibilities of such person, shall decide the appeal. References in this section to the "Plan Administrator" shall be deemed to constitute references to those persons to whom the Plan Administrator has delegated authority to decide appeals of denied claims.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written appeal should state why you think your claim should not have been denied. Your appeal should also include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in your appeal to the Claims Administrator. The review will not afford deference to the Claims Administrator's decision.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of any such individual.

The Plan Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For claims filed after April 1, 2018, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Plan Administrator or other person (or at the direction of the Plan or such other person) making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Plan Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.

If the Plan Administrator Makes an Adverse Benefit Determination on Your Appeal

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Plan Administrator makes an adverse benefit determination with respect to your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all

documents, records, and other information relevant to your claim; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Plan Administrator makes an adverse benefit determination on your claim on review, it will notify you in writing or electronically of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement indicating (A) your right to bring an action under section 502(a) of ERISA upon exhaustion of the claims procedure process, (B) that any such action must be brought no later than three years after the date an initial claim should have been filed under these claims procedures, and (C) the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Physical Examinations

The Company has the right, at its own expense, to have any person for whom a claim is pending examined as often as is reasonably necessary.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the time a claim should have been filed.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Long-Term Disability Plan

The claim determination and appeal process described below applies to the Long-Term Disability Plan. As used in this section, claims made under the Long-Term Disability Plan are referred to as "disability claims." The term "Plan" as used in this section refers to the Long-Term Disability Plan, and the term "Claims Administrator" refers to The Prudential Insurance Company of America. As used in this section, "adverse benefit determination" or "adverse determination" shall mean any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan, or (ii) any rescission of disability coverage with respect to a claimant (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 after the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For Disability Claims Filed On or Before April 1, 2018

For disability claims filed on or before April 1, 2018, if your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from the Claims Administrator of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the denial,
- references to the specific Plan provisions on which the benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process,

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

For Disability Claims Filed After April 1, 2018

For disability claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, it shall provide you with a written notice of the adverse benefit determination setting forth

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following completion of all required appeals;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

First Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim for benefits, you or your representative may appeal the determination in writing to the Claims Administrator within 180 days of your receipt of written notice of the adverse determination. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your written request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, without regard to whether such information was submitted or

considered in the initial adverse benefit determination, and utilizing individuals who were not involved, and who are not subordinates of the individuals involved, in that determination. This review will not afford any deference to the initial adverse benefit determination.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 45 days after the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, it shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, it shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For Disability Claims Filed On or Before April 1, 2018

For disability claims filed on or before April 1, 2018, if the claim on appeal is denied in whole or in part, you will receive a written notification from the Claims Administrator of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- the specific reason(s) for the adverse determination,
- references to the specific Plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures; and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

For Disability Claims Filed After April 1, 2018

For disability claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your disability claim on review, it will provide you with written notice. The notice shall set forth, in a manner calculated to be understood by you,

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures;
- a statement indicating
  - your right to bring an action under section 502(a) of ERISA upon completion of all required appeals,
  - that any such action must be brought no later than three years after the date of the adverse benefit determination with respect to your first appeal to the Claims Administrator, and
  - the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Second Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim on review, you or your representative may make a second, voluntary appeal of the adverse determination in writing to the Claims Administrator within 180 days of your receipt of the written notice of adverse benefit determination. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

The Claims Administrator shall make a determination on your second claim appeal within a reasonable period of time, but not later than 45 days after the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Claims Administrator expects to render a decision shall be furnished to you within the

initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, it shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, it shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under the Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the Claims Administrator makes an adverse benefit determination with respect to your second-level, voluntary appeal, you will receive a written notification from the Claims Administrator of the adverse determination. The notice will be written in a manner calculated to be understood by you and shall include the same type of information that was included in the letter notifying you of the adverse benefit determination on your first-level appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud, (ii) any error the Claims Administrator makes in processing a claim, and (iii) your receipt of deductible sources of income. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, unless otherwise provided under federal law, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date of the adverse benefit determination with respect to your first appeal to the Claims Administrator.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States

District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a

manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary, and
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon,

or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan. Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." For example, as of the date of this Handbook, the personnel policy of the Company and each Participating Employer is to terminate your employment if the claims fiduciary of the Company's long-term disability plan determines you no longer qualify for benefits under the long-term disability plan. The leaves referred to above are:

Sick Leave – Coverage under the Medical, Dental, Vision and FSA Plans for you and your eligible dependents continues if you are on sick leave and your Employer under its personnel policies continues to treat you as an employee. Your contributions for this coverage will continue to be deducted from your check.

Long Term Disability Leave ("LTD") – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents, as well as coverage under the Health Care FSA, continues if you are on LTD leave and your Employer under its personnel policies continues to treat you as an employee. You must continue to make your required contribution. You may also receive an Employer contribution to your Health Savings Account if you are enrolled in an HDPPO coverage option and are eligible to contribute to a Health Savings Account.

You **cannot** continue to participate in the Dependent Care FSA while you are receiving Long-Term Disability Plan benefits. You may, however, use the existing balance in your account to pay for any eligible expense you incur before you commence your LTD leave.

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other

coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;

- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care FSA, you may continue your current contributions

to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to

provide any group health plan or coverage to any employee.

- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at **dol.gov/ebsa** (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any

other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to

any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected

Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions;

and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

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

Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Medical Coverage for Retirees

You may be eligible for medical benefits as a retired employee if you meet certain eligibility requirements. For further information about your eligibility for medical benefits as a retired employee or to notify the Company or your Employer of your retirement, contact the Benefits Source at **1-888-640-3320**.

Unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , if you retire or otherwise terminate employment and are later rehired by the Company, a Participating Employer, or any of their affiliates, you will not be eligible for retiree medical or retiree life insurance benefits, including after your subsequent retirement or other termination of employment.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible†	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

†Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	**Out-of-Network**
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

	PPO	
	In-Network (or out of area)	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible.

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

	HDPPO 1		HDPPO 2	
FEATURE	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse	$3,000	$6,000	$5,000	$10,000
Covered Member + Child(ren)				
Covered Member + Family				

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain prescription drug

purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and
  - Prescribed medications (Outpatient prescription drug services are covered

under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).

- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam

and one hearing aid per ear during a two calendar-year period; and

- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor

performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;

- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance, when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

See the following website for additional information:
https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;
  - Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);
  - Screening for gestational diabetes;

- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

  - Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

  - Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
  - Inpatient covered hospital services related to the transplant procedure.
  - Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay*
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:		Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications	

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day

Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

Please Note: Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Preventive Dental

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:
  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process –* Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network

schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA FEATURES	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. A non-exhaustive list of eligible expenses can be found later in this section.
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A non-exhaustive list of eligible expenses can be found later in this section.*

FSA FEATURES	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;

- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;

- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website **mysourceforhr.com**.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 42.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax*

purposes. Please consult your tax advisor for more information.

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out

of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Travel Accident Plan

Your Travel Accident Benefit

This is the SPD (the "Travel Accident SPD") for the NiSource Travel Accident Plan, also referred to as the Travel Accident Plan. In this Travel Accident SPD, the Travel Accident Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the Plan to eligible employees to cover accidental death sustained during the course of a trip made on behalf of a Participating Employer.

For purposes of the Plan, a trip "made on behalf of a Participating Employer" means travel and sojourn authorized by, or at the direction of, a Participating Employer for purposes of furthering the business of the Participating Employer. A trip will be considered as commencing when you leave your residence or place of employment, whichever you leave last, for the purpose of going on such trip, and the trip will continue until you return to your residence or place of regular employment, whichever you return to first.

All eligible employees are covered for $50,000 in death benefits.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process – Travel Accident Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 44.

Eligibility

For information regarding eligibility under the Travel Accident Plan, please see the *"Eligibility under the Travel Accident Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Travel Accident Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Travel Accident Plan"*.

Contributions

The Employer pays the full cost of the Travel Accident Plan. There are no employee contributions.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Travel Accident Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Travel Accident Plan"*.

Beneficiary Designation

Your beneficiary will be the beneficiary or beneficiaries that you named under the NiSource Life Insurance Plan. (Please see the "*Life and AD&D Plan"* section of this Handbook for further details on beneficiary designation.)

If you fail to designate a beneficiary before your death, or if your beneficiary dies before you die, benefits are paid according to the default rules established under the NiSource Life Insurance Plan.

You and your beneficiary need to keep the Company advised of the addresses at which each of you can be located. If the Company cannot locate you or your beneficiary when benefits become payable, notification will be mailed to the most recent address on file. The Claims Administrator is not required to search for, or locate, you or your beneficiary. Please be sure to notify the Benefits Source should you or your beneficiary change addresses.

If a beneficiary becomes entitled to a payment under the Plan and it cannot be

made because (1) the current address is incorrect, (2) the beneficiary does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

To designate or change your beneficiary(ies) go online via the Benefits Source website at mysourceforhr.com or call the Benefits Source toll-free number at **1-888-640-3320** to speak with a customer service associate.

Travel Accident Benefit Exclusions

The Plan does not cover any accidental death incurred due to:

- Commuting to and from work, and any travel during lunches, breaks and vacations;
- Suicide or any attempted suicide while sane or self-destruction or an attempted suicide while insane;
- Declared or undeclared war or any act of either within the United States, the District of Columbia or Canada;
- Service in the armed forces of any country; provided, however, orders to active military service for two months or less will not constitute service in the armed forces; or
- Sickness or disease, except infections that occur through an accidental cut or wound.

Filing a Claim

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim under the claims procedures described below.

In the event of death or covered loss, your beneficiary must contact the NiSource Benefits Department at 801 E. 86th Avenue, Merrillville, Indiana 46410 within 31 days or as soon as reasonably possible in order to receive benefits.

Any claims submitted after 18 months from the date of death or covered loss may not be considered for payment.

The Plan pays benefits based on the coverage that was in effect on the date of your death. The benefit is paid in the form of a lump-sum payment.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Travel Accident Plan."*

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Travel Accident Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Travel Accident
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Company and Participating Employers
Contribution Source:	Employer
Plan Sponsor:	NiSource Inc. 801 E. 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 E. 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Claims are administered by the Claims Administrator listed below Benefits will be paid under the Plan only if the applicable Plan Administrator or its delegate (e.g. the Claims Administrator) determines that the claimant is entitled to them.
Claims Administrator:	NiSource Benefits Department 801 E. 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

Service of legal process may be made upon the Plan Administrator

Short-Term Disability Plan

Your Short-Term Disability Plan

This is the SPD for the NiSource Short-Term Disability Plan (the "Plan" or "Short-Term Disability Plan").

NiSource Inc. (the "Company") and the Participating Employers provide eligible employees with short-term disability ("STD") and sick leave coverage under the Plan at no cost to the employee. Your Employer provides you with limited income continuation should you become Disabled and unable to work because of a short-term Sickness or Injury (as defined below).

How Your Paid Sick Leave Works

Generally, if you are an eligible employee, you are granted paid sick leave on the first day of the month coincident with or next following the completion of six continuous months of active full-time employment with an Employer. All covered absences due to Sickness or Injury will be deducted from your sick leave balance and will be paid in accordance with the schedule set forth in the *"Highlights of Your Short-Term Disability Plan Coverage"* section of this SPD.

Your Plan benefit is determined by your credited service years. Please see the *"Highlights of Your Disability Plan Coverage"* section for further details.

If you use all of your paid sick leave time and you are still unable to return to work, you will be on an unpaid leave of absence. You may continue in this unpaid status until:

- You are eligible to receive Long Term Disability Plan Benefits;
- You return to work;
- You terminate employment; or
- You retire.

If you are still on sick leave at the end of December and you remain unable to work into the next calendar year, you continue to use remaining sick leave from the previous year. Subject to the terms, conditions and limitations described below in "*Recurring or Separate Periods of Disability," y*ou will not receive additional hours of paid leave until you return to work for one full day in the new year. This means that you will not be granted additional hours of paid sick leave for the new year while you are absent due to Sickness or Injury.

For purposes of the Plan, "Sickness" means a disease, disorder or condition of the body or mind, including pregnancy, abortion, miscarriage or childbirth, that requires treatment by a Physician (as defined below), but does not include an Injury. Disability resulting from a Sickness must begin while you are covered under the Plan.

For purposes of the Plan, "Injury" means a bodily injury that is the direct result of an accident, that is not related to any cause other than the accident, the results in immediate disability, and that requires treatment by a Physician. Disability resulting from an Injury must begin while you are covered under the Plan.

Disability Under the Short-Term Disability Plan

If you are Disabled (as described below), you will be eligible for Plan benefits for up to maximum period of 26 weeks, at which time you may be eligible to receive Long-Term Disability Plan benefits. (See the *"Long-Term Disability Plan"* section of this Health and Welfare Benefits Handbook for details.) For Plan benefit purposes, as explained in greater detail below, you are considered "Disabled" or to have incurred a "Disability" if your Sickness (including pregnancy) or Injury prevents you from performing the essential functions of your own occupation.

There are different types of Disabilities for which you may qualify. They are defined as follows:

Total Disability

You are considered Totally Disabled if you are mentally or physically unable, due to Sickness or Injury, to perform the essential functions of your own occupation or any job requiring similar education or training that an Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case and you are absent from work for

more than four consecutive work days, you must be under the regular care of a Physician* and furnish proof of your Disability to the Claims Administrator. As used in the Plan, "essential functions" means functions that (i) are normally required for performance of your own occupation or any job requiring similar education or training that an Employer offers you and for which you are reasonably qualified by reason of your education, training, or experience, and (ii) cannot be reasonably omitted or modified.

Partial Disability

You are considered Partially Disabled if you are mentally or physically unable, due to Sickness or Injury, to perform, on a full time basis, the essential functions of your own occupation or any job requiring similar education or training that an Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case and you are absent from work for more than four consecutive days, you must be under the regular care of a Physician* and furnish proof of your Disability to the Claims Administrator.

Please Note: If you are Partially Disabled, you may be assigned temporary modified work. The temporary modified work assignment must be approved by your personal physician, the Company physician (where appropriate) and your supervisor.

Please Note: If you require a professional license or certification for your occupation and you lose that license or certification, the loss (in and of itself) does not constitute a Disability under the Plan.

**As used in this SPD, "Physician" means a person who is performing tasks that are within the limits of his or her medical license and is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or who has a doctoral degree in psychology (Ph.D or Psy.D) whose primary practice is treating patients; or who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction. It cannot be any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you send to us.*

Recurring or Separate Periods of Disability

If you are collecting Plan benefits due to a Disability, you temporarily recover, you return to work for your Employer for 180 consecutive calendar days or less, and you then again become Disabled due to the same or a related Sickness or Injury, your subsequent Disability is considered a recurring Disability. This means that you will be entitled to benefits for the recurring Disability for the maximum benefit period, less the benefits you have already received for that Disability.

If you are collecting Plan benefits, you temporarily recover, you return to work for your Employer for 181 or more consecutive calendar days, and you then again become Disabled due to the same Sickness or Injury, your Disability is considered a separate Disability. This means that you will be entitled to benefits for the separate Disability for your maximum benefit period. This amount will not be reduced by the benefits you already received for that Disability.*

*However, in no event will you entitled to benefits under the Plan during a calendar year in excess of the benefits applicable to you as described in the schedule set forth in the *"Highlights of Your Short-Term Disability Plan Coverage"* section of this SPD.

Eligibility

For information regarding eligibility under the Short-Term Disability Plan, please see the *"Eligibility under the Short-Term Disability Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Short-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Short-Term Disability Plan"*.

Contributions

Your Employer pays the full cost of the Plan. There are no employee contributions.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Short-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Short-Term Disability Plan"*.

Highlights of Your Short-Term Disability Plan Coverage

Your Plan benefit is determined according to your length of service and can extend up to 26 weeks during a calendar year, based on the following schedule:

CREDITED YEARS OF SERVICE	You Receive 100% of Your Base Salary for the First…	Then You Receive 60% of Your Base Salary for the Remaining…
More Than Six Months of Service But Less Than One Year of Service	1 Week	0 Weeks
From One Year of Service to Nine Years of Service	8 Weeks	18 Weeks
From Ten Years of Service to Nineteen Years of Service	16 Weeks	10 Weeks
Twenty or More Years of Service	26 Weeks	0 Weeks

For purpose of determining the number of weeks of benefits to which you are entitled, Base Salary and Years of Service shall be determined as of the January 1st immediately prior to the date of Total Disability, except that

(i) if you have more than six months but less than one Year of Service, Base Salary and Years of Service shall be determined as of the date of Total Disability, and

(ii) (ii) if you are a rehired employee who is entitled to credit for prior Years of Service, in the year you are rehired, Base Salary shall be determined as of the date of Total Disability and Years of Service shall be determined as of the date of your rehire according to rules described below with respect to crediting of service for rehires.

Your Plan benefits may end prior to the periods set forth in this schedule for reasons described in the "When Benefits End" section below.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the time a claim should have been filed. For more information, see the *"Claims Determination and Appeal Proc*ess – STD Plan*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 50.

Determining Years of Service

Generally

Upon your first year anniversary, you are credited with one Year of Service. On the December 31 following your first anniversary and each subsequent December 31 thereafter, you are credited with an additional Year of Service.

Crediting of Service for Rehires

If you terminated employment with, or retired from, an Employer and are rehired, you will receive credit under the Plan for Years of Service as follows:

Date of Rehire	Credit for Years of Service
Less than one year after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, including time of break
At least one year, but less than five years, after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, but excluding time during break in service.
At least five years after termination of employment or retirement from employment	No service credit. Participant begins with zero Years of Service upon rehire.

Crediting of Service for Rehires Who Previously Worked for Columbia Pipeline Group

If (i) you were an active employee of Columbia Pipeline Group, Inc. or its affiliates as of July 1, 2015, (ii) you terminated employment, or retired from employment, with Columbia Pipeline Group, Inc. or its affiliates on or after July 1, 2015, and (iii) you were thereafter rehired by an Employer, you will receive credit under the Plan for Years of Service as follows:

Date of Rehire	Credit for Years of Service
On or after July 1, 2015 and before July 1, 2016	All service with an Employer from the date of original hire prior to July 1, 2015 to and including the date of rehire by an Employer on or after July 1, 2015.
On or after July 1, 2016 and before July 1, 2020	All service with an Employer from the date of original hire prior to July 1, 2015, to and including June 30, 2015
On or after July 1, 2020	No service credit. Participant begins with zero Years of Service upon rehire.

Determination of Benefits Generally

Subject to the "How Your Paid Sick Leave Works" and the "Recurring or Separate Periods of Disability" sections of this SPD and upon your first year anniversary, you are entitled to receive benefits for the full benefit period of 26 weeks (1040 hours) for each calendar year.

To determine your Plan benefit, the Plan takes a percentage of your Base Salary*. This is called your "gross Plan benefit" The Plan then deducts any "other sources of disability income" from this amount to determine your "net Plan benefit."

Special provisions apply and are described below if you are Partially Disabled and are able to perform a temporary modified work assignment.

*"Base salary" means your basic earnings plus any before tax deposits deferred under a qualified retirement plan of an Employer. If you receive sales commissions, your Base Salary will be your average hourly wage based on the 12 consecutive calendar months immediately preceding the last day you were actively at work.

Your Base Salary does not include:

- Overtime;
- Shift differentials;
- Bonuses; or
- Any other form of special compensation.

Other Sources of Disability Income

You may be eligible for income from other sources due to your Disability. If this is the case, your benefits under the Plan will be fully offset by such other sources of Disability income.

Other sources of Disability income for which you are eligible, or that have been paid to you or to a third party on your behalf may include, but are not limited to, the amount of any benefit for loss of income for the same Disability from:

- The United States Social Security Act, the Railroad Retirement Act, the Jones Act, or similar plan or act
- Any temporary or permanent disability benefits under a Workers' Compensation law (does not include permanent impairment award), occupational disease law, or similar law
- The Veteran's Administration or any other foreign or domestic governmental agency
- Any governmental law or program that provides disability or unemployment benefits as a result of your employment with an Employer, including any state disability program;
- Disability benefits from any compulsory "no-fault" automobile insurance.

If you receive a benefit from another source of income in the form of a single lump sum, the amount of offset to the weekly benefit amount will be determined by prorating the lump sum over a period of 26 weeks.

State Disability Programs

If you work in a state that requires a state-defined disability plan, you are also covered under the provisions of the laws and regulations of that state plan. Your gross Plan benefit is reduced by the amount you are eligible to receive under any state disability program.

Applying for Other Sources of Disability Benefits

If you are eligible to receive disability benefits from other sources, you should apply as soon as possible. You should notify the Claims Administrator that you are eligible to receive other disability income as soon as possible.

When Benefits End

Your benefit payments will end as set forth in the schedule above, or sooner if any of the following events occur:

- You fail to submit evidence of your Disability or such other documents (if any) that the Plan deems necessary to administer the Plan, in accordance with Plan procedures;
- You do not comply with the Plan's request for evidence of your continuing Disability,

an independent medical examination or other examinations or tests;

- You fail or refuse to perform any temporary modified work assignment, in the case of a Partial Disability;
- You fail to participate in or comply with all requirements of the Disability Management Program;
- You are engaged in any other occupation or earn any self-employment income in excess of a de minimis amount;
- You are not under the regular care of a physician as required by your condition or you are not following the physician's treatment plan;
- You participate in and are convicted of a felony offense. In such case, your Disability will be determined to have ceased as of the date that you first participated in the felony offense;
- You commit or partake in any actions of fraud against the Plan or an Employer;
- You are no longer considered by the Plan to be Disabled;
- Your 26-week benefit period ends;
- You become eligible for LTD Plan benefits;
- You have been terminated or have voluntarily terminated employment with an Employer (other than transfer to another Employer);
- You are no longer eligible for coverage under the Plan; or,
- You die.

Plan Benefit Exclusions

The Plan does not pay benefits under certain circumstances. These circumstances include, but may not be limited to, the following:

- Failure to participate in or provide the Disability Management Program with all the required documentation regarding your Disability.
- Sickness or Injury that occurs while:
  - You are on a leave of absence;
  - You are furloughed from work;
  - You are suspended from work; or
  - You are considered an inactive employee.
- Disability that is caused or contributed to by an intentionally self-inflicted injury.
- If you are absent from work for more than four consecutive work days and the disability is not being treated by a Physician.
- Disability caused or contributed to by war or an act of war (declared or not).
- Disability caused by your commission of or attempt to commit a crime for which you have been convicted, or to which a contributing cause was your involvement in an illegal occupation.

Claiming Benefits

If you are unable to work because of Sickness or Injury, you must adhere to the following procedures to qualify for Plan benefits:

- Call your supervisor before your normal work day begins. If that is not possible, be sure to contact your supervisor as soon as you can. If you cannot call in, please be sure that someone calls in on your behalf. *Your Employer may require that you provide a Physician's statement confirming your Sickness or Injury before your absence is actually approved.*
- If you are, or know you will be, absent from work for more than four consecutive work days, call the Benefits Source at **1-888-640-3320** or the Claims Reporting Hotline at 1-877-ENERGY4, Option #3, then Option #1, to report your Sickness or Injury to the Plan's Disability Management Program.

Disability Management Program

You must participate in the Disability Management Program to qualify for Plan benefits. The Disability Management Program certifies that you qualify for Plan benefits beyond the fourth day of absence. You will

be assigned a "Claims Administrator" who will:

- Guide you through the disability benefits that may apply to your situation;
- Certify whether your disability qualifies for STD pay; and
- Help develop a reasonable return-to-work plan with you, your physician, and your supervisor.

You will be expected to participate fully in the Disability Management Program. You must:

- Supply the authorization and documentation as described in the following section;
- Maintain contact with your Claims Administrator;
- Follow the medical treatment plan that is agreed to by your Claims Administrator and your physician; and
- Return to work at the time that is agreed to by you, your Claims Administrator, your physician, and your supervisor.

Authorization and Documentation You Will Need to Supply

Upon request from the Claims Administrator, you may need to provide certain information. Failure to provide this information may deny, suspend or terminate your Plan benefits. The information includes, but is not limited to the following:

- Signed authorization form for the Claims Administrator to obtain all reasonably necessary medical, financial, or other non-medical information that supports your Disability claim.
- Proof that you have applied for other sources of disability income (i.e., Workers' Compensation, State Disability Benefits, or Social Security Disability Benefits, when applicable).
- Notification of when you receive or are awarded a benefit from another source of disability income, including the:
  - Type of income benefit;
  - Amount you are receiving;
  - Period for which the benefit applies; and
  - Duration for which the benefit is being paid (if you are receiving installment payments).

Also, your Employer may require a "doctor's release" to return to work.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Short-Term Disability Plan."*

Other Information

If Your Disability Reaches Five Months in Duration

You should apply for Social Security disability benefits by the end of the fourth month from the day your Disability began. (The Claims Administrator can help you with the filing process). In addition, if you are eligible to receive disability benefits from another source, you should apply as soon as possible.

Temporary Modified Work Assignment

If you qualify for a Partial Disability and you are working on a temporary modified work assignment, you will receive your Base Salary for the hours you work and Plan benefits (based on the Plan's provisions) for the hours you are not working.

If, in the Claims Administrator's opinion, you could perform a temporary modified work assignment (given your condition) and you refuse the assignment, the Plan benefit for which you would be otherwise eligible ends.

Family and Medical Leave Act (FMLA)

While collecting Plan benefits, you may also be eligible for leave under the Family and

Medical Leave Act of 1993 (FMLA). If you are eligible for and approved for a FMLA leave for your own serious health condition, your FMLA leave will run concurrently with Plan coverage for up to 12 weeks. Please refer to your Employer's FMLA Policy.

Continuation of Other Coverages

Certain coverages provided to you under the Program may continue while you are receiving Plan benefits or if you have an appeal pending in accordance with the provisions of the Plan. Any contributions that you are required to make toward the cost of these coverages (as well as your contributions to a retirement plan sponsored by an Employer) will be deducted from your Plan benefits. If your Plan benefits are insufficient to cover all of your benefit deductions, the Benefits Source will work with you to set up a direct billing arrangement. If you have any questions regarding these coverages, call the Benefits Source at **1-888-640-3320.**

Medical, Dental, Vision, and FSA Plans

For continuation of coverage under the Medical, Dental, Vision, and FSA Plans , see the General-Sick Leave subsection of the section of the **Benefits Program Overview** entitled "Continuation of Coverage under the Medical, Dental, Vision and FSA Plans."

Life and AD&D

Life and AD&D coverage for you and your eligible dependents continues.

LTD Disability

LTD coverage continues.

(Please Note: If your Disability continues and you meet the eligibility requirements, you may qualify for Long-Term Disability Plan benefits. See the *"Long-Term Disability Plan"* section of this Handbook for details.)

Retirement Plans

You continue to earn service under any retirement plan sponsored by an Employer for which you are otherwise eligible while collecting Plan benefits. In addition, you can continue to make elective deferrals (and the Company will continue to make matching contributions, as applicable) to any retirement plan allowing elective deferrals for which you are otherwise eligible while you are collecting Plan benefits. You may, however, stop your contribution to such retirement plan(s) at any time. Please see the applicable retirement plan(s) for further information.

Other Programs

If benefits under the Adoption Assistance Plan would otherwise be available to you, these benefits will not be available to you while you are collecting Plan benefits.

Contact Information

If you need answers to specific coverage related questions, contact the Benefits Source by going to their website or using their automated telephone system. Both the website and the automated telephone system can connect you with the Claims Administrator (if necessary).

Coverage Option	Contact
Short-Term Disability Plan	ESIS mysourceforhr.com (link to ESIS.com) **1-888-640-3320** (Benefits Source) You can connect with the Claims Administrator by phone via the Benefits Source automated telephone system.

General Plan Information

Program Name	NiSource Welfare Benefits Program
Plan Name:	NiSource Short-Term Disability Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Short-Term Disability
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions, and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5539
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under the Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., the Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	ESIS Two Riverway Suite 1100 Houston, Texas 77056
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410 Service of legal process may also be made upon the Plan Administrator.

Long-Term Disability Plan

Basic LTD Coverage

Supplemental LTD Coverage

Your Long-Term Disability Options

NiSource Inc. (the "Company") offers the NiSource Long-Term Disability Plan (the "Plan") to eligible employees with the following coverage options:

- Basic LTD Coverage Option; and
- Supplemental LTD Coverage Option.

Benefits are provided under a group insurance contract (the "Group Contract") and a group insurance certificate (the "Group Insurance Certificate") issued by The Prudential Insurance Company of America ("Prudential"), who is the Claims Administrator and is wholly responsible for the payment of benefits.

You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description. *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at* ***1-888-640-3320****.*

The Plan provides financial protection for you by paying a portion of your income while you have a long period of disability. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits begin after the elimination period is completed. The elimination period is the period of continuous disability that must be satisfied before you are eligible to receive benefits and is the longest of (i) 180 days; (ii) the length of time for which you receive loss of time benefits, salary continuation or accumulated sick leave; and (iii) the date that you are absent from work for 1040 hours due to your disability.

If you are determined to be disabled, the Basic LTD Coverage Option provides monthly benefits of the lesser of (i) 50% of your monthly earnings, not reduced by any deductible sources of income, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $8,333.00.

If you are determined to be disabled, the Supplemental LTD Coverage Option provides monthly benefits of the lesser of (i) 60% of your monthly earnings, not reduced by any deductible sources of income, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $10,000.00. You pay a portion of the cost of the Supplemental LTD Coverage Option.

Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under the Plan. See *"Taxability of Monthly Benefits"* below for information regarding the taxability of monthly benefits you receive under the Plan. Refer to the Group Insurance Certificate for further details.

See "*Highlights of the Long-Term Disability Plan Coverage*" below for examples illustrating the payment of monthly benefits.

Eligibility

For information regarding eligibility under the Long-Term Disability Plan, please see the *"Eligibility under the Long-Term Disability Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Long-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Long-Term Disability Plan"*.

Contributions

The Basic LTD Coverage Option is provided at no cost to you. If you elect the Supplemental LTD Coverage Option, you and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. *If you have questions regarding the amount of your required contributions, please contact the Benefits Source at* ***1-888-640-3320****.*

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Long-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends –Long-Term Disability Plan"*.

Highlights of the Long-Term Disability Plan Coverage

The information below describes how the Plan pays benefits if a participant becomes disabled and is unable to work and when a participant becomes disabled, but continues working. See *"Taxability of Monthly Benefits"* below for information regarding the taxability of monthly benefits you receive under the Plan.

If you are Disabled and Not Working

If you have the Basic LTD Coverage Option, your Monthly Payment is the lesser of:

- 50% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $8,333.00 per month.

If you have elected the Supplemental LTD Coverage Option, your monthly payment is the lesser of:

- 60% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $10,000.00 per month

If You Are Disabled and Working

If your monthly disability earnings ("Disability Earnings") are less than 20% of your indexed monthly earnings ("Indexed Monthly Earnings"), your LTD benefit is the same as it would be if you were not working.

If your Disability Earnings are greater than 80% of your Indexed Monthly Earnings, no benefit is payable to you. If benefits have already commenced, Prudential will stop sending you payments and your claim will end.

If you are disabled and your monthly Disability earnings are at least 20%, but not more than 80%, of your Indexed Monthly Earnings, due to the same sickness or injury, Prudential will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as Disability Earnings plus the gross disability payment does not exceed 100% of Indexed Monthly Earnings.

1. Add your monthly Disability Earnings to your gross disability payment.
2. Compare the answer in item 1 to your Indexed Monthly Earnings.

If the answer from item 1 is less than or equal to 100% of your Indexed Monthly Earnings, Prudential will not further reduce your monthly payment.

If the answer from item 1 is more than 100% of your Indexed Monthly Earnings, Prudential will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your Disability.

1. Subtract your Disability Earnings from your Indexed Monthly Earnings.
2. Divide the answer in item 1 by your Indexed Monthly Earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

The minimum monthly payment is the greater of (a) 10% of the gross disability payment otherwise payable, and (b) $100.

If your Disability Earnings are expected to fluctuate widely from month to month, Prudential may average your Disability Earnings over the most recent 3 months to determine if your claim should continue subject to all other terms and conditions of the Plan. If Prudential averages your

Disability Earnings, it will terminate your claim if the average of your Disability Earnings form the last 3 months exceeds 80% of Indexed Monthly Earnings. Prudential will not pay you for any month during which Disability Earnings exceed the foregoing amounts.

Definition of "Disability"

You are "disabled" when Prudential determines that:

- you are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury;
- you have a 20% or more loss in your monthly earnings due to that sickness or injury; and
- you are under the regular care of a doctor.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury,

- you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and
- you are under the regular care of a doctor.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received by Prudential within 30 days of its request.

Prudential may require you to be examined by doctors, other medical practitioners or vocational experts of its choice. It will pay for these examinations. Prudential can require examinations as often as it is reasonable to do so. It may also require you to be interviewed by an authorized Prudential Representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Additional Definitions

Active employment means you are classified as working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least 40 hours per week. Your worksite must be: your Employer's usual place of business; an alternate worksite at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or a location to which your job requires you to travel. Normal vacation is considered active employment. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Deductible sources of income means income from deductible sources listed in the Group Insurance Certificate that you receive or are entitled to receive while you are disabled. This income may be subtracted from your gross disability payment. Examples of deductible sources of income include but are not limited to (a) amounts you receive or are entitled to receive as (i) loss of time benefits under a workers' compensation law, an occupational disease law or any other act or law with similar intent; or (ii) loss of time disability income payments under any state compulsory benefit act or law, any insurance, health or welfare plan or other group insurance plan where the Employer, directly or indirectly, has paid all or part of the cost or made payroll deductions, or any governmental retirement system as a result of your job with your Employer; (b) the gross amount you receive or are entitled to receive as loss of time disability payments because of your disability under the United States Social Security Act or any similar plan or act; (c) the gross amount you receive as retirement payments under the United States Social Security Act or any similar plan or act; (d) the amount your receive as "wages" under the maritime doctrine of maintenance, wages and cure; and (e) the amount you receive, due to your disability, from a third party (after subtracting attorneys' fees and a pro-rata share of reasonable fees and costs) by judgement, settlement or otherwise. Refer to

the Group Insurance Certificate for a complete list of these sources.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations: (i) during the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation, that is reasonably available; and (ii) beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience. Salary continuance paid to supplement your disability earnings will not be included as disability earnings because it is not payment for work performed.

Gainful occupation means an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 50% of your monthly earnings, if you are not working. However, if you enrolled in the Supplemental LTD Coverage Option, it means an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 60% of your monthly earnings, if you are not working

Gross disability payment means the benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1, provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Injury means a bodily injury that is the direct result of an accident, that is not related to any other cause, and that results in immediate disability. Disability must begin while you are covered under the Plan.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, Prudential will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Monthly earnings means your total annual income before taxes divided by 12. It is determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer. Commissions will be averaged for the lesser of: (a) the 24 full calendar month period of your employment with your Participating Employer just prior to the date disability begins; or (b) the period of actual employment with your Employer.

Regular occupation means the occupation you are routinely performing when your disability occurs. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the Plan.

Taxability of Monthly Benefits

Because your Employer pays the entire cost of your Basic LTD Coverage and does not include this cost in your gross-income, and because you pay for any Supplemental LTD Coverage

on a pre-tax basis, any monthly benefits you receive under the Plan will be taxable to you pursuant to the Code and guidance issued thereunder.

Maximum Period of Payments

The longest period of time the Plan will make payments to you for any one period of disability (your "maximum period of payment") is as follows:

Your Age on Date Disability Begins	Your Maximum Period of Payment
Less than 60	To age 65
Age 60 and over	60 months

Prudential will stop sending you payments while you are incarcerated as a result of a conviction.

In addition, Prudential will stop sending you payments and your claim will end on the earliest of the following:

- During the first 24 months of payments, when you are able to work in your regular occupation on a "part-time basis" but you choose not to; after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to. "Part-time basis" means the ability to work and earn 20% or more of your indexed monthly earnings.
- The end of the maximum period of payment.
- The date you are no longer disabled under the terms of the Plan.
- The date you fail to submit proof of continuing disability satisfactory to Prudential.
- The date your disability earnings exceed the amount allowable under the Plan.
- The date you retire.
- The date you die.
- The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by your doctor.

Notwithstanding the above, disabilities due to a sickness or injury which, as determined by Prudential, are primarily based on self-reported symptoms have a limited pay period during your lifetime. "Self-reported symptoms" means the manifestations of your condition, which you tell your doctor, that are not verifiable using tests, procedures and clinical examinations standardly accepted in the practice of medicine. Examples include, without limitation, headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Also, disabilities which, as determined by Prudential, are due in whole or part to mental illness also have a limited pay period during your lifetime. "Mental illness" means a psychiatric or psychological condition regardless of cause and includes, without limitation, schizophrenia, depression, manic depressive, or bipolar illness, anxiety, somatization, substance related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

The limited pay period for self-reported symptoms and mental illness combined is 24 months during your lifetime. There are exceptions to the limited pay period rules. Refer to the Group Insurance Certificate for a detailed explanation of these exceptions.

Recurrent Disabilities

If you have a "recurrent disability," as determined by Prudential, your disability will be treated as part of your prior claim and you will not have to complete another elimination period if (a) you were continuously insured under the Plan for the period between your prior claim and your current disability; and (b) your recurrent disability occurs within 180 days of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the Plan as your prior claim.

Any disability which occurs after 180 days from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the Plan provisions.

If you become covered under any other group long term disability plan, you will not be eligible for payments under the Plan.

A "recurrent disability" is a disability that is (a) caused by a worsening in your condition; and (b) due to the same cause(s) as your prior disability for which the Plan made a Long Term Disability payment.

Exclusions from Coverage

The Plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot; or
- commission of a crime for which you have been convicted under state or federal law.

The Plan does not cover a disability which is due to a pre-existing condition.

The plan does not cover a disability due to war, declared or undeclared, or any act of war.

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available; and
- Your disability begins within 12 months of the date your coverage under the Plan becomes effective.

Pre-existing conditions may also affect an increase in your benefits due to an amendment of the Plan or your enrollment in another Plan option. *For further details, refer to the Group Insurance Certificate. You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

Survivor Benefits

When Prudential receives proof that you have died, it will pay your spouse, if living; otherwise, your children under age 25 (your "eligible survivors"), a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. However, Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

Other Services Provided Under the Plan

As part of your coverage under the Plan, Prudential also provides certain benefits in the nature of a Social Security Claimant Assistance Program, a Rehabilitation Program and a program of reimbursing employers for the cost of certain worksite modifications that are identified by your Employer and Prudential as being likely to help you remain at work or return to work. Refer to the Group Insurance Certificate for further details regarding these programs. With respect to the Rehabilitation Program, if at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease paying your monthly benefit.

Filing A Claim

General

Written notice of a claim should be sent to Prudential within 30 days after the date your disability begins. However, you must send Prudential written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than

1 year after the time proof is otherwise required except in the absence of legal capacity. You must notify us immediately when you return to work in any capacity.

*Claim forms can be obtained from Prudential by phone via the Benefits Source at **1-888-640-3320**, or online via the Benefits Source website at mysourceforhr.com. If you do not receive the form from Prudential within 15 days of your request, send Prudential written proof of claim without waiting for the form.*

How to File Claims

You and your Employer must fill out your own section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and send it directly to Prudential.

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a doctor.
- Appropriate documentation of your monthly earnings.
- The date your disability began.
- Appropriate documentation of the disabling disorder.
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation.
- The name and address of any hospital or institution where you received treatment, including all attending doctors.
- The name and address of any doctor you have seen.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by Prudential.

In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by Prudential. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.

Recovery of Overpayments

Prudential has the right to recover any overpayments due to (i) fraud; (ii) any error Prudential makes in processing a claim, and (iii) your receipt of deductible sources of income.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Long-Term Disability Plan."*

Continuation of Other Coverages

Certain coverages provided to you under the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program continue while you are Disabled and receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee. Any contributions that you are required to make toward the cost of these coverages will be billed to you. For further information regarding the billing arrangement, contact the Benefits Source.

Medical, Prescription Drug, Vision and Dental
Medical, vision and dental coverages for you and your eligible dependents continue while you are receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Life and AD&D
Life and AD&D coverages for you and your eligible dependents continue while you are

receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Health Care Flexible Spending Account

Your Health Care FSA coverage continues while you are receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee.

Dependent Care Flexible Spending Account

You cannot continue to make contributions to the Dependent Care FSA while you are receiving Plan benefits. You may use the existing balance in your account to pay for any eligible expense that you incurred prior to the commencement of your Plan benefits.

HSAs

You may receive an Employer contribution to your HSA if you are enrolled in an HDPPO coverage option and are otherwise eligible to contribute to a Health Savings Account. You may also contribute to your HSA while you are receiving Plan benefits; however your contribution may not be funded out of your Plan benefit payments.

Retirement Plans

While you are receiving Plan benefits, you may continue to earn service under your retirement plans. However, your contributions to the Savings Plan automatically stop. You are eligible to receive the value of your Savings Plan Account due to your disability. Refer to the Savings Plan and your other retirement plans for further information.

Other Programs

The Adoption Assistance and the Tuition Reimbursement Programs are not available to you while you are receiving Plan benefits.

Important Information For Residents Of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and in this summary plan description. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this summary plan description. Prudential has a website that describes these state-specific requirements. You may access the website at prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 93191.

If you are unable to access this website, and if you want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Long-Term Disability Plan (a component of NiSource Welfare Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing disability benefits
Plan Number:	537
Contribution Source:	Basic LTD Coverage: Employer Supplemental LTD Coverage: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102
Claims Administrator: (if you need to submit a claim)	The Prudential Insurance Company of America Prudential Disability Management Services P.O. Box 13480 Philadelphia, Pennsylvania 19176
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. ***In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail***. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

The Prudential Insurance Company of America, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Life and AD&D Plan

Employee Term Life Coverage -Basic and Optional Plans

Dependents Term Life Coverage

Employee AD&D Coverage - Basic and Supplemental Plans

Dependents AD&D Coverage

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Optional Employee Term Life Coverage Option;
- Dependents Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;
- Supplemental Employee AD&D Coverage Option; and
- Dependents AD&D Coverage Option

The Life and AD&D Coverage Options other than the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option are referred to collectively as the "Optional Life and AD&D Coverage Options."

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance") and, if elected, on the persons of your "eligible dependents" ("Dependents Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option. If you elect coverage under any of the Optional Life and AD&D Coverage Options, you will pay for the cost of such coverage. *If you have questions regarding the amount of your required contributions, please contact the Benefits Source at **1-888-640-3320**.*

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and

AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in an amount up to two times (2x) your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. If you are also enrolled in Optional Employee Term Life Coverage, the amount of your Basic Employee Term Life Coverage will be added to your Optional Term Life Coverage before rounding takes place. The maximum benefit (for Basic and Optional Employee Term Life Coverage combined) is $1,500,000. Amounts otherwise payable as benefits will be reduced by the amount of any Accelerated Benefits paid under the Option to Accelerate Payment of Death Benefits.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Optional Employee Term Life Coverage

You may enroll in one of the options below for optional term life coverage.

	Amount of Insurance (Multiple of Annual Earnings)	
Benefit Classes	**Sum of Basic + Optional**	**Optional**
Option 1	3x annual Earnings	1x annual Earnings
Option 2	4x annual Earnings	2x annual Earnings
Option 3	5x annual Earnings	3x annual Earnings
Option 4	6x annual Earnings	4x annual Earnings
Option 5	7x annual Earnings	5x annual Earnings

If the amount of your Basic Employee Term Life Coverage, when added to the amount of your Optional Employee Term Life Coverage, is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. However, the maximum benefit for Basic and Optional Employee Term Life Coverage combined is $1,500,000. Amounts otherwise payable as benefits will be reduced by the amount of any Accelerated Benefits paid under the Option to Accelerate Payment of Death Benefits.

Any requested change in coverage (increase or decrease) must be made within 31 days of a qualified life event or in connection with annual enrollment.

Notwithstanding the foregoing, the amount of your coverage may not exceed the "guaranteed issue amount" unless you submit evidence of insurability that is satisfactory to Securian and you are actively at work. The "guaranteed issue amount" is the lesser of (1) three times (3x) your annual Earnings, and (2) $500,000. Also, you must submit evidence of insurability if you are first applying for coverage under the Optional Employee Term Life Coverage Option during annual enrollment and your application is made more than 31 days after the date you first became eligible for coverage.

Without limiting the generality of the foregoing, you will need to provide evidence of insurability

- If you are a regular new hire or newly eligible for coverage and you apply for coverage under the Optional Employee Term Life Coverage Option in an amount greater than three times (3x) your annual Earnings (Basic plus Optional Coverage combined), or if the total amount of your Term Life Coverage after giving effect to your Optional Employee Term Life Coverage exceeds $500,000;
- If you are first applying for coverage under the Optional Employee Term Life Coverage Option during annual enrollment and the date you apply during annual enrollment is more than 31 days after your date of hire or the date you newly became eligible for coverage;
- If you are currently enrolled in the Optional Employee Term Life Coverage Option, you want to increase your coverage during annual enrollment, and the amount of your requested increase is greater than one times (1x) your annual Earnings, or the total amount of your Term Life Coverage after giving effect to your requested increase in coverage exceeds $500,000;
- If you request an increase in coverage due to a qualified life event and the amount of your requested increase is greater than one times (1x) your annual Earnings, or the total amount of your combined coverage under the Basic Employee Term Life Coverage Option and the Optional Employee Term Life Coverage Option (your "Employee Term Life Insurance") after giving effect to your requested increase in coverage exceeds $500,000;
- If you desire life insurance coverage and have an individual life insurance contract you obtained by converting your coverage under the Plan;
- The insurance for which you previously enrolled did not go into effect or was terminated because you failed to make a required premium contribution; and
- If you have not met a previous evidence requirement to become insured under any plan a Participating Employer has with Securian.

Any new enrollment or requested increase in coverage that is subject to evidence of insurability will become effective when Securian decides the evidence is satisfactory and you are actively at work; provided, however, that any such new enrollment or requested increase in coverage that is made in connection with annual enrollment will be effective on the later of (1) the following January 1, and (2) the first day of the month following the date Securian decides the evidence is satisfactory and you are actively at work.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any

lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option or the Optional Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor.

The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000. The maximum death benefit eligible for an Accelerated Benefit is $1,000,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

If you elect an Accelerated Benefit and the termination of your Employee Term Life Insurance causes an eligible dependent to lose life insurance coverage, he or she will be allowed to convert any such insurance to a policy of individual life insurance as discussed below under the section entitled "Conversion Privilege for Life Coverage."

If the amount of your Employee Term Life Insurance exceeds the maximum Accelerated Benefit, your Employee Term Life Insurance coverage (reduced by the amount of the Accelerated Benefit) will continue after your election of the Accelerated Benefit and your premiums will be reduced accordingly. The amount of the Accelerated Benefit will be applied first to reduce your outstanding Optional Employee Term Life Coverage and

then to reduce your outstanding Basic Employee Term Life Coverage.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Dependents Term Life Coverage

Under the Dependents Term Life Coverage Option, you may enroll your "eligible dependents" for coverage in the amounts shown below.

Your spouse who is an "eligible dependent"	
Benefit Classes	**Amount of Insurance**
Option 1	$10,000
Option 2	$25,000
Option 3	$50,000

Your children who are "eligible dependents"	
Benefit Classes	**Amount of Insurance***
Option 1	$5,000
Option 2	$10,000

You must provide evidence of insurability under the following circumstances:

- If you choose Option 3 spousal coverage (coverage in the amount of $50,000);
- If any dependent's coverage for which you previously enrolled did not go into effect under the Plan or was terminated because you did not pay a required contribution;
- If, during a previous period of eligibility, you failed to submit evidence of insurability that was required for a dependent or that which was submitted was not satisfactory to Securian; or
- Your dependent is insured by an individual policy issued under the terms of the conversion right.

Option 3 spousal coverage will become effective on the date Securian decides the evidence of insurability is satisfactory.

If a dependent (other than a newborn child) is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released form such hospitalization or confinement.

No enrollment or increases in coverage may become effective so long as your "eligible dependents" are confined for medical care or treatment, whether at home or elsewhere.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Payment of Death Benefits under Life Coverage

If you or your "eligible dependent" dies while covered under the Plan, the amount of insurance on you or your "eligible dependent" is payable when Securian's home office receives written proof satisfactory to it that you or your eligible dependent died while covered under the Plan and insured under the Group Insurance Certificate. If you or an "eligible dependent" die within 31 days after ceasing to be covered under the Plan, but while you or your "eligible dependent," as the case may be, are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of

insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules. Death benefits under the Dependents Term Life Coverage Option are payable to you, if you are living. If you are not living, benefits are payable to your estate.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance or your coverage under the Dependents Term Life Coverage Option terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features"* below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in an amount up to two times (2x) your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit (for Basic and Supplemental Employee AD&D Coverage combined) is $1,500,000.

Supplemental Employee AD&D Coverage Option

You may enroll for supplemental employee AD&D coverage in any multiple of $10,000 up to the lesser of (1) ten times your annual Earnings, and (2) $1,500,000 minus the amount of your insurance under the Basic Employee AD&D Coverage Option).

Dependents AD&D Coverage Option

You may enroll for AD&D coverage on each of your "eligible dependents" in an amount equal to a percentage of your Supplemental Employee AD&D Coverage, as set forth below:

Eligible dependents	Amount of Insurance on each Eligible Dependent (as % of Employee AD&D Coverage)
Spouse only	60% on spouse
Child(ren) only	10% on each child
Spouse and child(ren)	50% on spouse; 10% on each child

Additional AD&D Coverage

The Plan provides additional benefits under the Basic, Supplemental Employee, and Dependents AD&D Coverage Options for a person's loss of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance on the person, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including

Reserve or National Guard active duty for training); (8) travel in or descent from any aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance and the Dependents Term Life Coverage Option, except that you or your "eligible dependent," as the case may be, may convert the amount of insurance under the Employee Term Life Insurance or the Dependents Term Life Coverage Option that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You and your eligible dependents are eligible to continue your Employee Insurance and Dependents Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date, but not more than $1,000,000 for an employee or $50,000 for a spouse. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date to a maximum of $650,000 for an employee or $32,500 for a spouse.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000. This minimum does not apply to a dependent.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) in the case of your dependent child or a spouse who is covered under the Plan, the date your coverage is no longer being continued under the Portability Plan or the date your spouse or child ceases to be eligible under the Plan; or

(4) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life, Optional Life, Dependent Life, be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No. except for conversion of Dependent Life	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

*Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at **1-888-640-3320**, or online via the Benefits Source website at* mysourceforhr.com. *If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process –Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Non-Exempt, Non-Union, Part-Time Employees Hired or Rehired On or After January 1, 2013

Contents

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular part-time non-exempt, non-union employees hired or rehired on or after January 1, 2013 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 109.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement

under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program**

Overview and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note: It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues; and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Medical, Dental or Vision Plan.*

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year,

you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months prior to the month in which you apply for benefits, but not earlier than the first month you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular part-time employee of a Participating Employer, (ii)

regularly work less than 40 hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, and vision coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO coverage under the Medical Plan), basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

> **Please Note:**
>
> Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (collectively referred to as "Employee Life and AD&D Insurance").

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your

child(ren) under the same plan. Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates.

You will be advised of any new benefit plans, plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage"* for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;
- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day.

If you are not actively at work on the date coverage would otherwise begin, you will not be eligible for the coverage until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Coverage Ends

Your Employee Life and AD&D Insurance will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D Coverage Option, the date such Life and AD&D Coverage Option is terminated;
- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular part-time employee or as a member of another eligible class;

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active part-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or

whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, or the Flexible Benefits Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***
- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for

details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

In the case of a divorce or separation, the following order will establish responsibility for payment:

— If there is a court order that requires a parent to take financial responsibility

for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.

- The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.
- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.
- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits,

the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide

should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well

as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;

- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or

vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical

necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of

any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based

upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care

claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the

Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a

health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the

determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims

Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which

event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for

matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary, and
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the

written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA

following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan.

Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." The leaves referred to above are:

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other

coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;

- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care FSA, you may continue your current contributions

to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to

provide any group health plan or coverage to any employee.

- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at **dol.gov/ebsa** (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any

other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to

any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected

Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions;

and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

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

Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible†	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

†Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	Out-of-Network
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	Out-of-Network
	Plan Pays	Plan Pays
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

	HDPPO 1		HDPPO 2	
FEATURE	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$3,000	$6,000	$5,000	$10,000

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at 1-888-640-3320 for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain prescription drug

purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 28.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and
  - Prescribed medications (Outpatient prescription drug services are covered

under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).

- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam

and one hearing aid per ear during a two calendar-year period; and

- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor

performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;

- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance, when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

See the following website for additional information:
https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;
  - Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);
  - Screening for gestational diabetes;

- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

  - Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

  - Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
  - Inpatient covered hospital services related to the transplant procedure.
  - Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay*
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:		Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications	

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

[Material continued on next page]

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

***Please Note**:* Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

[Material continued on next page]

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Preventive Dental

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network

schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA FEATURES	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. *A non-exhaustive list of eligible expenses can be found later in this section.*
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A non-exhaustive list of eligible expenses can be found later in this section.*

FSA FEATURES	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;

- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;

- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website **mysourceforhr.com**.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 36.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax*

purposes. Please consult your tax advisor for more information.

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out

of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Life and AD&D Plan

Employee Term Life Coverage – Basic Plan

Employee AD&D Coverage – Basic Plan

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in the amount of $20,000.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 39.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor. The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Payment of Death Benefits under Life Coverage

If you die while covered under the Plan, the amount of insurance on you is payable when Securian's home office receives written proof satisfactory to it that you died while covered under the Plan and insured under the Group Insurance Certificate. If you die within 31 days after ceasing to be covered under the Plan, but while you are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features*" below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in the amount of $20.000.

Additional AD&D Coverage

The Plan provides additional benefits under the Basic AD&D Coverage Option for your loss of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including Reserve or National Guard active duty for training); (8) travel in or descent from any

aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 39.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance, except that you may convert the amount of insurance under the Employee Term Life Insurance that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You are eligible to continue your Employee Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No.	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at ***1-888-640-3320****, or online via the Benefits Source website at* mysourceforhr.com*. If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process –Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Non-Exempt, Non-Union, Full-Time Employees Hired or Rehired On or After January 1, 2013

Contents

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular full-time non-exempt, non-union employees hired or rehired on or after January 1, 2013 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 108.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Travel Accident Coverage (NiSource Travel Accident Plan – referred to as the "Travel Accident Plan")

- Short-Term Disability Coverage (NiSource Short-Term Disability Plan – referred to as the "Short-Term Disability Plan")
- Long-Term Disability Coverage (NiSource Long-Term Disability Plan – referred to as the "Long-Term Disability Plan")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the

applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a

person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview** and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note: It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be

denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues; and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at ***mysourceforhr.com****, or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether*

you are eligible to participate in the Medical, Dental or Vision Plan.

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year, you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months prior to the month in which you apply for benefits, but not earlier than the first month you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits*

*Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Travel Accident Plan

If you are classified as a full-time employee, you will be eligible to participate in the Travel Accident Plan as of your first day of active, full-time employment with a Participating Employer. You are a "full-time employee" if you are characterized by your Employer as a full-time employee who regularly works 40 or more hours per week.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Travel Accident Plan.*

Eligibility under the Short-Term Disability Plan

If you are a full-time employee who was hired before January 1, 2017, you were covered under the Short-Term Disability Plan as of the first day of the month coincident with or next following your completion of six continuous months of active, full-time employment with a Participating Employer. If you are a full-time employee who was hired on or after January 1, 2017, you will be covered under the Short-Term Disability Plan as of your first day of active, full-time employment with a Participating Employer. You are a "full-time employee" if you are characterized by your Employer as a full-time employee who regularly works 40 hours per week. Newly hired employees must be actively at work on the date coverage is scheduled to begin.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Short-Term Disability Plan.*

Eligibility under the Long-Term Disability Plan

You are eligible to participate in the Long-Term Disability Plan if you are a regular full-time employee of a Participating Employer who works 40 or more hours per week and are in active employment. You are in active employment if you are working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. Your worksite must be your Employer's usual place of business, an alternate work site at the direction of your Employer other than your home, unless clear specific expectations and duties are documented, or a location to which your job requires you to travel. Your eligibility for optional, contributory coverage may be subject to your satisfying other requirements established by Prudential Insurance Company of America. Refer to the group insurance certificate issued by Prudential for more details.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Long-Term Disability Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular full-time employee of a Participating Employer, (ii) regularly work 40 or more hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

Your eligibility for optional, contributory coverage may be subject to your providing evidence of insurability and satisfying other

requirements established by the insurer, Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc.

See the Life and AD&D Benefit Plan section below and refer to the group insurance certificate issued by Securian for further details.

Eligible Dependents

If you are eligible to participate in the Life and AD&D Plan, you may obtain certain coverage for your "eligible dependents." Your "eligible dependents" are:

- Your lawful Spouse, provided you are not legally separated; and
- Your unmarried children from live birth to the end of the month in which the unmarried child attains age 26; and

Your "children" include: (1) your natural children, legally adopted children and children placed with you for adoption prior to legal adoption; and (2) each of your stepchildren, foster children, children subject to legal guardianship, grandchildren, and other children who are blood relatives who depend on you for more than fifty percent of their support and maintenance. A child placed with you for adoption prior to legal adoption is considered an eligible dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

Notwithstanding the foregoing, your unmarried children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on you for more than 50% of their support and maintenance.

Also notwithstanding the foregoing,

(1) Your spouse is not your "eligible dependent" while on active duty in the armed forces of any country; and
(2) Your child is not your "eligible dependent" while (a) on active duty in the armed forces of any country; or (b) insured under any Employee Insurance.

A child will not be considered the "eligible dependent" of more than one employee. If this would otherwise be the case, the child will be considered the "eligible dependent" of the employee named in a written agreement of all such employees filed with the Company. If there is no written agreement, the child will be considered the "eligible dependent" of:

(1) the employee who became insured under the Plan with respect to the child while the child was an "eligible dependent" of only that employee; and otherwise
(2) the employee who has the longest continuous service with a Participating Employer, based on the Company's records.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Life and AD&D Plan.*

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, vision, supplemental and dependent life and AD&D and supplemental long-term disability coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO coverage under the Medical Plan), travel accident, short-term disability, basic long-term disability, basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.** To enroll in supplemental and dependent life and AD&D and supplemental long-term disability coverages, you must use enrollment forms approved by Securian (with respect to life and AD&D coverage) and Prudential (with respect to long-term disability coverage). You may obtain these enrollment forms by contacting the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

Please Note:

Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and*

Continuing Elections" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Travel Accident Plan

No affirmative enrollment is required for the Travel Accident Plan. You are automatically enrolled upon the date you become eligible for such coverage.

Enrollment in the Short-Term Disability Plan

No affirmative enrollment is required for the Short-Term Disability Plan. You are automatically enrolled upon the date you become eligible for such coverage.

Enrollment in the Long-Term Disability Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Long-Term Disability Plan*" section above, you will be automatically enrolled in the Basic LTD Coverage Option, unless you choose to enroll in the Supplemental LTD Coverage Option. Newly eligible employees must enroll in the Supplemental LTD Coverage Option within 31 days of their date of hire or, if later, the date they first become eligible for coverage. If you fail to enroll, you will automatically be covered under the Basic LTD Coverage Option. In general, once you enroll in (or decline) the Supplemental LTD Coverage Option, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.)

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (such Life and AD&D Coverage Options, together with the Optional Employee Term Life Coverage Option and the Supplemental Employee AD&D Coverage Option, are collectively referred to as "Employee Life and AD&D Insurance"). If you desire coverage under the Optional Employee Term Life Coverage Option, the Dependents Term Life Coverage Option, the Supplemental Employee AD&D Coverage Option, or the Dependents AD&D Coverage Option (collectively the "Optional Life and AD&D Coverage Options") as a newly eligible employee, you must enroll in such Optional Life and AD&D Coverage Option within 31 days of your date of hire or the date you become newly eligible. If you do not enroll in an Optional Life and AD&D Coverage Option during this initial 31-day period, you may need to provide evidence of insurability if you decide to enroll at a later date. You must enroll using forms approved by Securian. *You may obtain forms for*

enrolling in, or changing, your Optional Life and AD&D Coverage Options by contacting the Benefits Source at ***1-888-640-3320.***

In general, once you enroll in (or decline) any of the Optional Life and AD&D Coverage Options, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage election will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.) If any change in coverage is subject to evidence of insurability, Securian must decide that such evidence is satisfactory.

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your child(ren) under the same plan (e.g., child life insurance). Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates. You will be advised of any new benefit plans, plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a**

Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

Opt-Out Credit

If you are a full-time employee and have coverage elsewhere and decline medical or dental coverage under the Medical or Dental Plans, you may be eligible for an opt-out credit, if available. Please refer to the enrollment material to see if this option is currently being offered. If you have declined coverage, but your Spouse or parent is also an employee or retiree and is covering you as a dependent, you are not entitled to an opt-out credit. If you are a covered dependent under the Medical and/or Dental Plans, you must call the Benefits Source at **1-888-640-3320** during enrollment to update your status**.** The Company will recover payment of ineligible opt-out credits through payroll deductions.

Please Note:

If you have declined Medical Plan coverage, but your Spouse or parent is also an employee or retiree who is covering you under the Medical Plan as a dependent, you are not entitled to an opt-out credit. You must call the Benefits Source at **1-888-640-3320** during enrollment to update your status.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will

end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage"* for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;
- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Travel Accident Plan

Coverage Begins

Your Travel Accident Plan coverage becomes effective on the first day of your active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Travel Accident Plan for benefits on the earliest of the following:

- The date as of which the Plan is terminated;
- The date that the Plan is amended to terminate your coverage;
- The date you are no longer eligible for coverage under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy; and
- The date you terminate employment.

When Coverage Begins and Ends – Short-Term Disability Plan

Coverage Begins

Your Short-Term Disability Plan coverage became effective on the first day of the month coincident with or next following the date you completed six continuous months of active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Short-Term Disability Plan for benefits on the earliest of the following:

- The date the Plan is terminated;
- The effective date of any Plan amendment that terminates coverage with respect to you;
- The date you are no longer eligible for coverage under the Plan, including without limitation as a result of your Employer no longer being affiliated with the Company or no longer being a Participating Employer in the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994;
- The last day for which you made any required contribution toward the cost of Plan coverage;
- The date you begin any leave of absence; and
- The date your employment terminates.

When Coverage Begins and Ends – Long-Term Disability Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Long-Term Disability Plan,"* coverage under the Basic LTD Coverage Option of the Long-Term Disability Plan generally may become effective on the later of (1) your first day of active employment, for regular new hires, (2) the day you become a member of a class eligible for coverage under the Plan, (3) the first day of the following Plan Year, for eligible employees who choose not to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period, or (4) the date the Plan approves such enrollment, for employees who disenroll from the Supplemental LTD Coverage Option due to a qualified life event.

Coverage under the Supplemental LTD Coverage Option generally may become effective on the later of (1) the date you are eligible for coverage, if you enroll on or

before that date; (2) the date you enroll for coverage, if you enroll within 31 days after the date you are eligible for coverage; (3) the date Prudential approves your application, if evidence of insurability is required; (4) the date you are in active employment; (5) the first day of the following Plan Year, for eligible employees who choose to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period; or (6) the date the Plan approves such enrollment due to a qualified life event.

Evidence of insurability means a statement of your medical history that Prudential will use to determine if you are approved for coverage. You must give evidence of insurability, at your expense, if (1) you enroll for coverage more than 31 days after the date you are eligible for it; (2) you re-enroll for coverage after you voluntarily cancelled it; (3) you enroll after any coverage ends because you did not pay a required contribution; or (4) you have not met a previous evidence requirement to become covered under any plan NiSource has with Prudential. Prudential will decide when evidence of insurability is satisfactory.

Once your coverage begins, any increased or additional coverage will take effect on the latest of: (1) the effective date of the change, if you are in active employment, on a temporary layoff, on leave of absence, or working reduced hours (for reasons other than disability); (2) the date Prudential approves your application, if evidence of insurability is required; or (3) the date you return to active employment, if you are not in active employment due to injury or sickness.

Coverage Ends

Your coverage under the Long-Term Disability Plan will end on the date you lose eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the group insurance contract issued by The Prudential Insurance Company of America is canceled;
- The date that the Plan is amended to terminate your coverage;
- The date you terminate employment or are no longer eligible for coverage under the Plan;
- The date you are no longer in active employment due to a disability that is not covered under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made; or
- The date you are no longer in active employment, except as provided below and except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 ("FMLA").

If you are on a temporary layoff or are working reduced hours for reasons other than disability and the premium is paid, you will be covered to the end of the month following the month in which your temporary layoff or reduced hours begin. If you are on a leave of absence and the premium is paid, you will be covered to the end of the month in which your leave begins. Neither temporary layoff nor leave of absence includes normal vacation time or any period of disability or absence in connection with any severance or termination agreement. Your FMLA leave also is not considered a temporary layoff.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage,

provided you are actively at work on such day.

Provided you have satisfied the eligibility requirements described above, coverage under the Employee Optional Life and AD&D Coverage Options may generally become effective on the first day on which each of the following conditions are met: (1) you have enrolled for coverage, including, if required, applying for coverage on forms approved by the Claims Administrator, (2) with respect to the Optional Employee Term Life Coverage Option, the Claims Administrator is satisfied with your evidence of insurability, if evidence is required (provided that coverage will become effective as of the first day of the month following the Claims Administrator's determination that evidence is satisfactory), and (3) the Claims Administrator has received the required premium.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Provided you have satisfied the eligibility requirements described above, coverage of your "eligible dependents" under the Dependents Term Life Coverage Option and the Dependents AD&D Coverage Option ("Dependents Life and AD&D Insurance") generally may become effective on the first day on which each of the following conditions are met: (1) you have enrolled for dependent coverage, including, if required, applying for coverage on forms approved by the Claims Administrator, (2) the person to be covered is your "eligible dependent", (3) you are insured for employee coverage under the particular coverage sought (e.g., for the Dependents Term Life Coverage Option, you are covered under the Basic Employee Term Life Coverage Option, and for the Dependents AD&D Coverage Option, you are covered under the Supplemental Employee AD&D Coverage Option), (4) for the Dependents Term Life Coverage Option, the Claims Administrator is satisfied with your eligible dependent's evidence of insurability, if evidence is required, and (5) the Claims Administrator has received the required premium.

If an eligible dependent (other than a newborn child) is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement.

Evidence of your insurability may be required under certain circumstances if you apply for coverage under the Optional Employee Term Life Coverage Option. Evidence of your eligible dependent's insurability may also be required under certain circumstances if you apply for coverage for your eligible dependent under the Dependents Term Life Coverage Option. See the sections in the Life and AD&D Benefits Plan section below entitled *"Optional Employee Term Life Coverage"* and *"Dependents Term Life Coverage"* for more details concerning evidence of insurability requirements.

If you apply for coverage that requires evidence of insurability, your coverage election will be autocorrected to the greatest amount of coverage, consistent with your election, to which you would otherwise be entitled without evidence of insurability. Once evidence of insurability is approved by Securian, your coverage will be updated effective the first of the month following approval (or, if later, January 1, in the case of an election made during annual enrollment).

Coverage Ends

Your Employee Life and AD&D Insurance or Dependents Life and AD&D Insurance under a Life and AD&D Coverage Option will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D

Coverage Option, the date such Life and AD&D Coverage Option is terminated;

- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular full-time employee or as a member of another eligible class;
- For Life and AD&D Coverage Options that are contributory, 31 days after the due date of any required contribution that is not paid, provided that failure to contribute for Dependents Life and AD&D Insurance will not cause your Employee Life and AD&D Insurance to end;
- For the Dependents Term Life Coverage Option, the date your coverage under the Basic Employee Term Life Coverage Option ends;
- For the Dependents AD&D Coverage Option, the date your coverage under the Supplemental Employee AD&D Coverage Option ends;
- For Dependents Life and AD&D Insurance, the last day of the month in which your "eligible dependent" ceases to be an "eligible dependent" for the coverage or is no longer covered under the Group Contract.
- For coverage under an Employee Optional Life and AD&D Coverage Option, the last day for which premium contributions have been made following your written request to end coverage under such Employee Optional Life and AD&D Coverage Option.
- For Dependents Life and AD&D Insurance, the last day for which premium contributions have been made following your written request to end Dependents Life and AD&D Insurance for an "eligible dependent"

You must notify the Claims Administrator or the Benefits Source at **1-888-640-3320** when a dependent is no longer eligible for coverage under the Life and AD&D Plan so that premiums may be discontinued. No claims will be paid under the Life and AD&D Plan in respect of an ineligible dependent.

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active full-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, the Flexible Benefits Plan, the Life and AD&D Plan or the Long-Term Disability Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special

enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause),

termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***

- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the

other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

In the case of a divorce or separation, the following order will establish responsibility for payment:

- If there is a court order that requires a parent to take financial responsibility for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.
- The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.
- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.
- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits, the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims

Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations.

Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;
- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth

below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

- Your name;

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an

independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis

code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request

must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan’s internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator’s determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial,

reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse

benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims

Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with

written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the

services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Travel Accident Plan

The claim determination and appeal process described below applies to the Travel Accident Plan. As used in this section, (i) the term "Plan" refers to the Travel Accident Plan, and (ii) the term "Claims Administrator" refers to the NiSource Benefits Department or such other claims administrator appointed for the Plan. Any claim for benefits submitted after eighteen months from the date of a covered person's death may not be considered for payment.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

Within 90 days of receiving a claim, the Claims Administrator will provide your beneficiary with a written notice of its decision. If because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator Denies the Claim

If the Claims Administrator denies your beneficiary's claim in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the pertinent provisions in the Plan on which the denial is based;
- A description of any additional material or information necessary for your beneficiary to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals.

Appeal to Claims Administrator

If your beneficiary has a claim denied in whole or in part, your beneficiary has the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial.

Your beneficiary's request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Travel Accident Plan.

Your beneficiary may submit written comments, documents, records, and other information relating to the claim for benefits. Upon his or her request, your beneficiary will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Your beneficiary's written request should state why he or she thinks the claim should not have been denied. Your beneficiary's request also should include any adverse

benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your beneficiary's request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by your beneficiary relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

Your beneficiary will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator Denies the Appeal

If the Claims Administrator denies your beneficiary's appeal in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A statement that your beneficiary is entitled to receive upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits; and
- A statement indicating the beneficiary's right to file a lawsuit upon completion of the claims procedure process.

Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your beneficiary's claim on appeal, your beneficiary may file a written claim with the Plan Administrator within 60 days after your appeal has been denied in whole or in part by the Claims Administrator.

Any claim for benefits with the Plan Administrator will be processed within 60 days of its receipt unless additional time is required to process the claim, in which event your beneficiary will be notified that an additional period of 60 days is required to process the claim. The notice will include the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision.

If the Plan Administrator Denies the Appeal

If your beneficiary's claim for benefits is denied in whole or part by the Plan Administrator, written notice of the decision to deny such application will be promptly furnished to your beneficiary within 60 days after receipt of the claim for benefits, or within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the claim. Notwithstanding the foregoing, if the Plan Administrator's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Plan Administrator's final determination may be made within the period specified in Department of Labor Regulations Section 2560.503-1(i)(ii). Each notice of denial of an application shall be in writing and shall contain the following information:

- The specific reason or reasons for the denial;

- Specific references to the Plan provisions upon which the denial is based;
- A statement that your beneficiary is entitled to receive upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claimant has exhausted all claims and appeals to the Claims Administrator and Plan Administrator. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date of the covered person's death.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Short-Term Disability Plan

The claim determination and appeal process described below applies to the Short-Term Disability Plan. As used in this section, (i) the term "Plan" refers to the Short-Term Disability Plan, (ii) the term "Claims Administrator" refers to the applicable claims administrator appointed for the Plan, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in the Plan or a rescission of your disability coverage (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) before you request a formal appeal. If you are not satisfied with a benefit determination, you can appeal it.

Consideration of the Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but generally not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall

specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding Your Claim

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written or electronic notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- a description of the Plan's review procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following exhaustion of the claims procedure process;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding

you that was made by the Social Security Administration and that you presented to the Plan,

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits, you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 180 days of the receipt of the written adverse benefit determination.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request should also include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an individual who is neither the person who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such person.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claims Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For claims filed after April 1, 2018, before the Claims Administrator issues and averse benefit determination on appeal, it will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person (or at the direction of the Plan or such other person) making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on appeal based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which a notice of the adverse benefit

determination on review is required to be provided.

The Claims Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination on review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Appeal

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Claims Administrator makes an adverse benefit determination on your appeal, it will notify you of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the benefit determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- a statement indicating your right to file a lawsuit upon completion of the appeal process.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination on your appeal, it will notify you in writing or electronically of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement indicating (A) your right to bring an action under section 502(a) of ERISA upon exhaustion of the claims procedure process, (B) that any such action must be brought no later than three years after the date an initial claim should have been filed under these claims procedures, and (C) the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Appeal to the Plan Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim on review, you or your duly authorized representative may appeal the Claims Administrator's determination by sending a written request to the Plan Administrator within 45 days of your receipt of the Claims Administrator's adverse benefit determination on review.

The Committee, as Plan Administrator, has delegated to the Director, Benefits, the Director, Corporate Insurance and the Senior Vice President and Chief Human Resources Officer, and to the officers or employees of the Company or of its affiliates succeeding to the duties and responsibilities of such persons, the authority to decide appeals of denied claims on behalf of the Plan Administrator. Such appeals shall be decided by the Director, Benefits and the Director, Corporate Insurance, or by the officers or employees of the Company or of its affiliates succeeding to the duties and responsibilities of such persons. In the event such persons do not agree on the decision with respect to an appeal, the Senior Vice President and Chief Human Resources Officer, or the officer or employee of the Company or of its affiliates succeeding to the duties and responsibilities of such person, shall decide the appeal. References in this section to the "Plan Administrator" shall be deemed to constitute references to those persons to whom the Plan Administrator has delegated authority to decide appeals of denied claims.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written appeal should state why you think your claim should not have been denied. Your appeal should also include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in your appeal to the Claims Administrator. The review will not afford deference to the Claims Administrator's decision.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of any such individual.

The Plan Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For claims filed after April 1, 2018, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Plan Administrator or other person (or at the direction of the Plan or such other person) making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Plan Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.

If the Plan Administrator Makes an Adverse Benefit Determination on Your Appeal

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Plan Administrator makes an adverse benefit determination with respect to your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Plan Administrator makes an adverse benefit determination on your claim on review, it will notify you in writing or electronically of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;

- a statement indicating (A) your right to bring an action under section 502(a) of ERISA upon exhaustion of the claims procedure process, (B) that any such action must be brought no later than three years after the date an initial claim should have been filed under these claims procedures, and (C) the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Physical Examinations

The Company has the right, at its own expense, to have any person for whom a claim is pending examined as often as is reasonably necessary.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the time a claim should have been filed.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Long-Term Disability Plan

The claim determination and appeal process described below applies to the Long-Term Disability Plan. As used in this section, claims made under the Long-Term Disability Plan are referred to as "disability claims." The term "Plan" as used in this section refers to the Long-Term Disability Plan, and the term "Claims Administrator" refers to The Prudential Insurance Company of America. As used in this section, "adverse benefit determination" or "adverse determination" shall mean any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan, or (ii) any rescission of disability coverage with respect to a claimant (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely

pay required premiums or contributions towards the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 after the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For Disability Claims Filed On or Before April 1, 2018

For disability claims filed on or before April 1, 2018, if your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from the Claims Administrator of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the denial,
- references to the specific Plan provisions on which the benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process,

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

For Disability Claims Filed After April 1, 2018

For disability claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, it shall provide you with a written notice of the adverse benefit determination setting forth

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures, including a statement of your right to bring

a civil action under section 502(a) of ERISA following completion of all required appeals;

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

First Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim for benefits, you or your representative may appeal the determination in writing to the Claims Administrator within 180 days of your receipt of written notice of the adverse determination. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your written request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, without regard to whether such information was submitted or considered in the initial adverse benefit determination, and utilizing individuals who were not involved, and who are not subordinates of the individuals involved, in that determination. This review will not afford any deference to the initial adverse benefit determination.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 45 days after the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, it shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be

provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, it shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For Disability Claims Filed On or Before April 1, 2018

For disability claims filed on or before April 1, 2018, if the claim on appeal is denied in whole or in part, you will receive a written notification from the Claims Administrator of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- the specific reason(s) for the adverse determination,
- references to the specific Plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures; and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

For Disability Claims Filed After April 1, 2018

For disability claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your disability claim on review, it will provide you with written notice. The notice shall set forth, in a manner calculated to be understood by you,

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures;
- a statement indicating
  - your right to bring an action under section 502(a) of ERISA upon completion of all required appeals,
  - that any such action must be brought no later than three years after the date of the adverse benefit determination with respect to your first appeal to the Claims Administrator, and
  - the calendar date upon which such limitations period expires;

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Second Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim on review, you or your representative may make a second, voluntary appeal of the adverse determination in writing to the Claims Administrator within 180 days of your receipt of the written notice of adverse benefit determination. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

The Claims Administrator shall make a determination on your second claim appeal within a reasonable period of time, but not later than 45 days after the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Claims Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, it shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, it shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no

effect on your right to any other benefits under the Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the Claims Administrator makes an adverse benefit determination with respect to your second-level, voluntary appeal, you will receive a written notification from the Claims Administrator of the adverse determination. The notice will be written in a manner calculated to be understood by you and shall include the same type of information that was included in the letter notifying you of the adverse benefit determination on your first-level appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud, (ii) any error the Claims Administrator makes in processing a claim, and (iii) your receipt of deductible sources of income. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, unless otherwise provided under federal law, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date of the adverse benefit determination with respect to your first appeal to the Claims Administrator.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining

the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary, and
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,

- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will

receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the

State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan. Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." For example, as of the date of this Handbook, the personnel policy of the Company and each Participating Employer is to terminate your employment if the claims fiduciary of the Company's long-term disability plan determines you no longer qualify for benefits under the long-term disability plan. The leaves referred to above are:

Sick Leave – Coverage under the Medical, Dental, Vision and FSA Plans for you and your eligible dependents continues if you are on sick leave and your Employer under its personnel policies continues to treat you as an employee. Your contributions for this coverage will continue to be deducted from your check.

Long Term Disability Leave ("LTD") – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents, as well as coverage under the Health Care FSA, continues if you are on LTD leave and your Employer under its personnel policies continues to treat you as an employee. You must continue to make your required contribution. You may also receive an Employer contribution to your Health Savings Account if you are enrolled in an HDPPO coverage option and are eligible to contribute to a Health Savings Account.

You **cannot** continue to participate in the Dependent Care FSA while you are receiving Long-Term Disability Plan benefits. You may, however, use the existing balance in your account to pay for any eligible expense you incur before you commence your LTD leave.

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the

Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two

percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day

period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care FSA, you may continue your current contributions to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to provide any group health plan or coverage to any employee.
- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at dol.gov/ebsa (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an

available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;

- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who

shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director,

Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may

receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Benefit Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Benefit Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Benefit Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator

to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible†	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

†Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	**Out-of-Network**
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

	PPO	
	In-Network (or out of area)	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse	$3,000	$6,000	$5,000	$10,000
Covered Member + Child(ren)				
Covered Member + Family				

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain prescription drug

purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and
  - Prescribed medications (Outpatient prescription drug services are covered

under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).

- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam

and one hearing aid per ear during a two calendar-year period; and

- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor

performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;

- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance, when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

  See the following website for additional information:
  https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;
  - Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);

- Screening for gestational diabetes;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

- Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

- Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
- Inpatient covered hospital services related to the transplant procedure.
- Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	You Pay*
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

[Material continued on next page]

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

Please Note: Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

[Material continued on next page]

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Preventive Dental

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	You Pay		You Pay		You Pay	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:
  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

[Material continued on next page]

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process –* Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network

schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA FEATURES	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. *A non-exhaustive list of eligible expenses can be found later in this section.*
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A non-exhaustive list of eligible expenses can be found later in this section.*

FSA FEATURES	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;

- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;

- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website **mysourceforhr.com**.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 41.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax*

purposes. Please consult your tax advisor for more information.

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out

of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Travel Accident Plan

Your Travel Accident Benefit

This is the SPD (the "Travel Accident SPD") for the NiSource Travel Accident Plan, also referred to as the Travel Accident Plan. In this Travel Accident SPD, the Travel Accident Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the Plan to eligible employees to cover accidental death sustained during the course of a trip made on behalf of a Participating Employer.

For purposes of the Plan, a trip "made on behalf of a Participating Employer" means travel and sojourn authorized by, or at the direction of, a Participating Employer for purposes of furthering the business of the Participating Employer. A trip will be considered as commencing when you leave your residence or place of employment, whichever you leave last, for the purpose of going on such trip, and the trip will continue until you return to your residence or place of regular employment, whichever you return to first.

All eligible employees are covered for $50,000 in death benefits.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process – Travel Accident Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 44.

Eligibility

For information regarding eligibility under the Travel Accident Plan, please see the *"Eligibility under the Travel Accident Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Travel Accident Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Travel Accident Plan"*.

Contributions

The Employer pays the full cost of the Travel Accident Plan. There are no employee contributions.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Travel Accident Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Travel Accident Plan"*.

Beneficiary Designation

Your beneficiary will be the beneficiary or beneficiaries that you named under the NiSource Life Insurance Plan. (Please see the "*Life and AD&D Plan"* section of this Handbook for further details on beneficiary designation.)

If you fail to designate a beneficiary before your death, or if your beneficiary dies before you die, benefits are paid according to the default rules established under the NiSource Life Insurance Plan.

You and your beneficiary need to keep the Company advised of the addresses at which each of you can be located. If the Company cannot locate you or your beneficiary when benefits become payable, notification will be mailed to the most recent address on file. The Claims Administrator is not required to search for, or locate, you or your beneficiary. Please be sure to notify the Benefits Source should you or your beneficiary change addresses.

If a beneficiary becomes entitled to a payment under the Plan and it cannot be

made because (1) the current address is incorrect, (2) the beneficiary does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

To designate or change your beneficiary(ies) go online via the Benefits Source website at mysourceforhr.com or call the Benefits Source toll-free number at **1-888-640-3320** to speak with a customer service associate.

Travel Accident Benefit Exclusions

The Plan does not cover any accidental death incurred due to:

- Commuting to and from work, and any travel during lunches, breaks and vacations;
- Suicide or any attempted suicide while sane or self-destruction or an attempted suicide while insane;
- Declared or undeclared war or any act of either within the United States, the District of Columbia or Canada;
- Service in the armed forces of any country; provided, however, orders to active military service for two months or less will not constitute service in the armed forces; or
- Sickness or disease, except infections that occur through an accidental cut or wound.

Filing a Claim

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim under the claims procedures described below.

In the event of death or covered loss, your beneficiary must contact the NiSource Benefits Department at 801 E. 86th Avenue, Merrillville, Indiana 46410 within 31 days or as soon as reasonably possible in order to receive benefits.

Any claims submitted after 18 months from the date of death or covered loss may not be considered for payment.

The Plan pays benefits based on the coverage that was in effect on the date of your death. The benefit is paid in the form of a lump-sum payment.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Travel Accident Plan."*

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Travel Accident Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Travel Accident
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Company and Participating Employers
Contribution Source:	Employer
Plan Sponsor:	NiSource Inc. 801 E. 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 E. 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Claims are administered by the Claims Administrator listed below Benefits will be paid under the Plan only if the applicable Plan Administrator or its delegate (e.g. the Claims Administrator) determines that the claimant is entitled to them.
Claims Administrator:	NiSource Benefits Department 801 E. 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

Service of legal process may be made upon the Plan Administrator

Short-Term Disability Plan

Your Short-Term Disability Plan

This is the SPD for the NiSource Short-Term Disability Plan (the "Plan" or "Short-Term Disability Plan").

NiSource Inc. (the "Company") and the Participating Employers provide eligible employees with short-term disability ("STD") and sick leave coverage under the Plan at no cost to the employee. Your Employer provides you with limited income continuation should you become Disabled and unable to work because of a short-term Sickness or Injury (as defined below).

How Your Paid Sick Leave Works

Generally, if you are an eligible employee, you are granted paid sick leave on the first day of the month coincident with or next following the completion of six continuous months of active full-time employment with an Employer. All covered absences due to Sickness or Injury will be deducted from your sick leave balance and will be paid in accordance with the schedule set forth in the *"Highlights of Your Short-Term Disability Plan Coverage"* section of this SPD.

Your Plan benefit is determined by your credited service years. Please see the *"Highlights of Your Disability Plan Coverage"* section for further details.

If you use all of your paid sick leave time and you are still unable to return to work, you will be on an unpaid leave of absence. You may continue in this unpaid status until:

- You are eligible to receive Long Term Disability Plan Benefits;
- You return to work;
- You terminate employment; or
- You retire.

If you are still on sick leave at the end of December and you remain unable to work into the next calendar year, you continue to use remaining sick leave from the previous year. Subject to the terms, conditions and limitations described below in "*Recurring or Separate Periods of Disability," y*ou will not receive additional hours of paid leave until you return to work for one full day in the new year. This means that you will not be granted additional hours of paid sick leave for the new year while you are absent due to Sickness or Injury.

For purposes of the Plan, "Sickness" means a disease, disorder or condition of the body or mind, including pregnancy, abortion, miscarriage or childbirth, that requires treatment by a Physician (as defined below), but does not include an Injury. Disability resulting from a Sickness must begin while you are covered under the Plan.

For purposes of the Plan, "Injury" means a bodily injury that is the direct result of an accident, that is not related to any cause other than the accident, the results in immediate disability, and that requires treatment by a Physician. Disability resulting from an Injury must begin while you are covered under the Plan.

Disability Under the Short-Term Disability Plan

If you are Disabled (as described below), you will be eligible for Plan benefits for up to maximum period of 26 weeks, at which time you may be eligible to receive Long-Term Disability Plan benefits. (See the *"Long-Term Disability Plan"* section of this Health and Welfare Benefits Handbook for details.) For Plan benefit purposes, as explained in greater detail below, you are considered "Disabled" or to have incurred a "Disability" if your Sickness (including pregnancy) or Injury prevents you from performing the essential functions of your own occupation.

There are different types of Disabilities for which you may qualify. They are defined as follows:

Total Disability

You are considered Totally Disabled if you are mentally or physically unable, due to Sickness or Injury, to perform the essential functions of your own occupation or any job requiring similar education or training that an Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case and you are absent from work for

more than four consecutive work days, you must be under the regular care of a Physician* and furnish proof of your Disability to the Claims Administrator. As used in the Plan, "essential functions" means functions that (i) are normally required for performance of your own occupation or any job requiring similar education or training that an Employer offers you and for which you are reasonably qualified by reason of your education, training, or experience, and (ii) cannot be reasonably omitted or modified.

Partial Disability

You are considered Partially Disabled if you are mentally or physically unable, due to Sickness or Injury, to perform, on a full time basis, the essential functions of your own occupation or any job requiring similar education or training that an Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case and you are absent from work for more than four consecutive days, you must be under the regular care of a Physician* and furnish proof of your Disability to the Claims Administrator.

Please Note: If you are Partially Disabled, you may be assigned temporary modified work. The temporary modified work assignment must be approved by your personal physician, the Company physician (where appropriate) and your supervisor.

Please Note: If you require a professional license or certification for your occupation and you lose that license or certification, the loss (in and of itself) does not constitute a Disability under the Plan.

**As used in this SPD, "Physician" means a person who is performing tasks that are within the limits of his or her medical license and is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or who has a doctoral degree in psychology (Ph.D or Psy.D) whose primary practice is treating patients; or who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction. It cannot be any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you send to us.*

Recurring or Separate Periods of Disability

If you are collecting Plan benefits due to a Disability, you temporarily recover, you return to work for your Employer for 180 consecutive calendar days or less, and you then again become Disabled due to the same or a related Sickness or Injury, your subsequent Disability is considered a recurring Disability. This means that you will be entitled to benefits for the recurring Disability for the maximum benefit period, less the benefits you have already received for that Disability.

If you are collecting Plan benefits, you temporarily recover, you return to work for your Employer for 181 or more consecutive calendar days, and you then again become Disabled due to the same Sickness or Injury, your Disability is considered a separate Disability. This means that you will be entitled to benefits for the separate Disability for your maximum benefit period. This amount will not be reduced by the benefits you already received for that Disability.*

*However, in no event will you entitled to benefits under the Plan during a calendar year in excess of the benefits applicable to you as described in the schedule set forth in the *"Highlights of Your Short-Term Disability Plan Coverage"* section of this SPD.

Eligibility

For information regarding eligibility under the Short-Term Disability Plan, please see the *"Eligibility under the Short-Term Disability Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Short-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Short-Term Disability Plan"*.

Contributions

Your Employer pays the full cost of the Plan. There are no employee contributions.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Short-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Short-Term Disability Plan"*.

Highlights of Your Short-Term Disability Plan Coverage

Your Plan benefit is determined according to your length of service and can extend up to 26 weeks during a calendar year, based on the following schedule:

For Employees Hired Before January 1, 2017:

CREDITED YEARS OF SERVICE	You Receive 100% of Your Base Salary for the First…	Then You Receive 60% of Your Base Salary for the Remaining…
More Than Six Months of Service But Less Than One Year of Service	1 Week	0 Weeks
From One Year of Service to Nine Years of Service	8 Weeks	18 Weeks
From Ten Years of Service to Nineteen Years of Service	16 Weeks	10 Weeks
Twenty or More Years of Service	26 Weeks	0 Weeks

For Employees Hired On or After January 1, 2017:

CREDITED YEARS OF SERVICE	You Receive 100% of Your Base Salary for the First…	Then You Receive 60% of Your Base Salary for the Remaining…
Hired (or rehired with no credit for prior Years of Service) in 1st quarter of calendar year	4 days	0 days
Hired (or rehired with no credit for prior Years of Service) in 2nd quarter of calendar year	3 days	0 days
Hired (or rehired with no credit for prior Years of Service) in 3rd quarter of calendar year	2 days	0 days

CREDITED YEARS OF SERVICE	You Receive 100% of Your Base Salary for the First…	Then You Receive 60% of Your Base Salary for the Remaining…
Hired (or rehired with no credit for prior Years of Service) in 4th quarter of calendar year	1 day	0 days
January 1 after date of hire (or after date of rehire with no credit for prior Years of Service) to 9 years	8 weeks	18 weeks
10 years to 19 years	16 weeks	10 weeks
20 years or more	26 weeks	0 weeks

For purpose of determining the number of weeks of benefits to which you are entitled, Base Salary and Years of Service shall be determined as of the January 1st immediately prior to the date of Total Disability, except that

(i) for employees hired before January 1, 2017, (a) if you have more than six months but less than one Year of Service, Base Salary and Years of Service shall be determined as of the date of Total Disability, and (b) if you are a rehired employee who is entitled to credit for prior Years of Service, in the year you are rehired, Base Salary shall be determined as of the date of Total Disability and Years of Service shall be determined as of the date of your rehire according to rules described below with respect to crediting of service for rehires; and

(ii) for employees hired on or after January 1, 2017, in the year you are hired or rehired, Base Salary shall be determined as of the date of Disability and the calendar quarter in which you are hired or rehired shall be substituted for Years of Service, unless you are entitled to credit upon rehire for prior Years of Service, in which case Years of Service shall be determined as of the date of rehire.

Your Plan benefits may end prior to the periods set forth in this schedule for reasons described in the "When Benefits End" section below.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the time a claim should have been filed. For more information, see the *"Claims Determination and Appeal Proc*ess – STD Plan*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 50.

Determining Years of Service

Generally

Upon your first year anniversary, you are credited with one Year of Service. On the December 31 following your first anniversary and each subsequent December 31 thereafter, you are credited with an additional Year of Service.

Crediting of Service for Rehires

If you terminated employment with, or retired from, an Employer and are rehired, you will receive credit under the Plan for Years of Service as follows:

Date of Rehire	Credit for Years of Service
Less than one year after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, including time of break
At least one year, but less than five years, after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, but excluding time during break in service.
At least five years after termination of employment or retirement from employment	No service credit. Participant begins with zero Years of Service upon rehire.

Crediting of Service for Rehires Who Previously Worked for Columbia Pipeline Group

If (i) you were an active employee of Columbia Pipeline Group, Inc. or its affiliates as of July 1, 2015, (ii) you terminated employment, or retired from employment, with Columbia Pipeline Group, Inc. or its affiliates on or after July 1, 2015, and (iii) you were thereafter rehired by an Employer, you will receive credit under the Plan for Years of Service as follows:

Date of Rehire	Credit for Years of Service
On or after July 1, 2015 and before July 1, 2016	All service with an Employer from the date of original hire prior to July 1, 2015 to and including the date of rehire by an Employer on or after July 1, 2015.
On or after July 1, 2016 and before July 1, 2020	All service with an Employer from the date of original hire prior to July 1, 2015, to and including June 30, 2015
On or after July 1, 2020	No service credit. Participant begins with zero Years of Service upon rehire.

Determination of Benefits Generally

Subject to the "How Your Paid Sick Leave Works" and the "Recurring or Separate Periods of Disability" sections of this SPD and upon your first year anniversary, you are entitled to receive benefits for the full benefit period of 26 weeks (1040 hours) for each calendar year.

To determine your Plan benefit, the Plan takes a percentage of your Base Salary*. This is called your "gross Plan benefit" The Plan then deducts any "other sources of disability income" from this amount to determine your "net Plan benefit."

Special provisions apply and are described below if you are Partially Disabled and are able to perform a temporary modified work assignment.

*"Base salary" means your basic earnings plus any before tax deposits deferred under a qualified retirement plan of an Employer. If you receive sales commissions, your Base Salary will be your average hourly wage based on the 12 consecutive calendar months immediately preceding the last day you were actively at work.

Your Base Salary does not include:

- Overtime;
- Shift differentials;
- Bonuses; or
- Any other form of special compensation.

Other Sources of Disability Income

You may be eligible for income from other sources due to your Disability. If this is the case, your benefits under the Plan will be fully offset by such other sources of Disability income.

Other sources of Disability income for which you are eligible, or that have been paid to you or to a third party on your behalf may include, but are not limited to, the amount of any benefit for loss of income for the same Disability from:

- The United States Social Security Act, the Railroad Retirement Act, the Jones Act, or similar plan or act
- Any temporary or permanent disability benefits under a Workers' Compensation law (does not include permanent impairment award), occupational disease law, or similar law
- The Veteran's Administration or any other foreign or domestic governmental agency
- Any governmental law or program that provides disability or unemployment benefits as a result of your employment with an Employer, including any state disability program;
- Disability benefits from any compulsory "no-fault" automobile insurance.

If you receive a benefit from another source of income in the form of a single lump sum, the amount of offset to the weekly benefit amount will be determined by prorating the lump sum over a period of 26 weeks.

State Disability Programs

If you work in a state that requires a state-defined disability plan, you are also covered under the provisions of the laws and regulations of that state plan. Your gross Plan benefit is reduced by the amount you are eligible to receive under any state disability program.

Applying for Other Sources of Disability Benefits

If you are eligible to receive disability benefits from other sources, you should apply as soon as possible. You should notify the Claims Administrator that you are eligible to receive other disability income as soon as possible.

When Benefits End

Your benefit payments will end as set forth in the schedule above, or sooner if any of the following events occur:

- You fail to submit evidence of your Disability or such other documents (if any) that the Plan deems necessary to administer the Plan, in accordance with Plan procedures;
- You do not comply with the Plan's request for evidence of your continuing Disability,

an independent medical examination or other examinations or tests;

- You fail or refuse to perform any temporary modified work assignment, in the case of a Partial Disability;
- You fail to participate in or comply with all requirements of the Disability Management Program;
- You are engaged in any other occupation or earn any self-employment income in excess of a de minimis amount;
- You are not under the regular care of a physician as required by your condition or you are not following the physician's treatment plan;
- You participate in and are convicted of a felony offense. In such case, your Disability will be determined to have ceased as of the date that you first participated in the felony offense;
- You commit or partake in any actions of fraud against the Plan or an Employer;
- You are no longer considered by the Plan to be Disabled;
- Your 26-week benefit period ends;
- You become eligible for LTD Plan benefits;
- You have been terminated or have voluntarily terminated employment with an Employer (other than transfer to another Employer);
- You are no longer eligible for coverage under the Plan; or,
- You die.

Plan Benefit Exclusions

The Plan does not pay benefits under certain circumstances. These circumstances include, but may not be limited to, the following:

- Failure to participate in or provide the Disability Management Program with all the required documentation regarding your Disability.
- Sickness or Injury that occurs while:
  - You are on a leave of absence;
  - You are furloughed from work;
  - You are suspended from work; or
  - You are considered an inactive employee.
- Disability that is caused or contributed to by an intentionally self-inflicted injury.
- If you are absent from work for more than four consecutive work days and the disability is not being treated by a Physician.
- Disability caused or contributed to by war or an act of war (declared or not).
- Disability caused by your commission of or attempt to commit a crime for which you have been convicted, or to which a contributing cause was your involvement in an illegal occupation.

Claiming Benefits

If you are unable to work because of Sickness or Injury, you must adhere to the following procedures to qualify for Plan benefits:

- Call your supervisor before your normal work day begins. If that is not possible, be sure to contact your supervisor as soon as you can. If you cannot call in, please be sure that someone calls in on your behalf. *Your Employer may require that you provide a Physician's statement confirming your Sickness or Injury before your absence is actually approved.*
- If you are, or know you will be, absent from work for more than four consecutive work days, call the Benefits Source at 1-888-640-3320 or the Claims Reporting Hotline at 1-877-ENERGY4, Option #3, then Option #1, to report your Sickness or Injury to the Plan's Disability Management Program.

Disability Management Program

You must participate in the Disability Management Program to qualify for Plan benefits. The Disability Management Program certifies that you qualify for Plan benefits beyond the fourth day of absence. You will

be assigned a "Claims Administrator" who will:

- Guide you through the disability benefits that may apply to your situation;
- Certify whether your disability qualifies for STD pay; and
- Help develop a reasonable return-to-work plan with you, your physician, and your supervisor.

You will be expected to participate fully in the Disability Management Program. You must:

- Supply the authorization and documentation as described in the following section;
- Maintain contact with your Claims Administrator;
- Follow the medical treatment plan that is agreed to by your Claims Administrator and your physician; and
- Return to work at the time that is agreed to by you, your Claims Administrator, your physician, and your supervisor.

Authorization and Documentation You Will Need to Supply

Upon request from the Claims Administrator, you may need to provide certain information. Failure to provide this information may deny, suspend or terminate your Plan benefits. The information includes, but is not limited to the following:

- Signed authorization form for the Claims Administrator to obtain all reasonably necessary medical, financial, or other non-medical information that supports your Disability claim.
- Proof that you have applied for other sources of disability income (i.e., Workers' Compensation, State Disability Benefits, or Social Security Disability Benefits, when applicable).
- Notification of when you receive or are awarded a benefit from another source of disability income, including the:
  - Type of income benefit;
  - Amount you are receiving;
  - Period for which the benefit applies; and
  - Duration for which the benefit is being paid (if you are receiving installment payments).

Also, your Employer may require a "doctor's release" to return to work.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Short-Term Disability Plan."*

Other Information

If Your Disability Reaches Five Months in Duration

You should apply for Social Security disability benefits by the end of the fourth month from the day your Disability began. (The Claims Administrator can help you with the filing process). In addition, if you are eligible to receive disability benefits from another source, you should apply as soon as possible.

Temporary Modified Work Assignment

If you qualify for a Partial Disability and you are working on a temporary modified work assignment, you will receive your Base Salary for the hours you work and Plan benefits (based on the Plan's provisions) for the hours you are not working.

If, in the Claims Administrator's opinion, you could perform a temporary modified work assignment (given your condition) and you refuse the assignment, the Plan benefit for which you would be otherwise eligible ends.

Family and Medical Leave Act (FMLA)

While collecting Plan benefits, you may also be eligible for leave under the Family and

Medical Leave Act of 1993 (FMLA). If you are eligible for and approved for a FMLA leave for your own serious health condition, your FMLA leave will run concurrently with Plan coverage for up to 12 weeks. Please refer to your Employer's FMLA Policy.

Continuation of Other Coverages

Certain coverages provided to you under the Program may continue while you are receiving Plan benefits or if you have an appeal pending in accordance with the provisions of the Plan. Any contributions that you are required to make toward the cost of these coverages (as well as your contributions to a retirement plan sponsored by an Employer) will be deducted from your Plan benefits. If your Plan benefits are insufficient to cover all of your benefit deductions, the Benefits Source will work with you to set up a direct billing arrangement. If you have any questions regarding these coverages, call the Benefits Source at **1-888-640-3320.**

Medical, Dental, Vision, and FSA Plans

For continuation of coverage under the Medical, Dental, Vision, and FSA Plans , see the General-Sick Leave subsection of the section of the **Benefits Program Overview** entitled "Continuation of Coverage under the Medical, Dental, Vision and FSA Plans."

Life and AD&D

Life and AD&D coverage for you and your eligible dependents continues.

LTD Disability

LTD coverage continues.

(Please Note: If your Disability continues and you meet the eligibility requirements, you may qualify for Long-Term Disability Plan benefits. See the *"Long-Term Disability Plan"* section of this Handbook for details.)

Retirement Plans

You continue to earn service under any retirement plan sponsored by an Employer for which you are otherwise eligible while collecting Plan benefits. In addition, you can continue to make elective deferrals (and the Company will continue to make matching contributions, as applicable) to any retirement plan allowing elective deferrals for which you are otherwise eligible while you are collecting Plan benefits. You may, however, stop your contribution to such retirement plan(s) at any time. Please see the applicable retirement plan(s) for further information.

Other Programs

If benefits under the Adoption Assistance Plan would otherwise be available to you, these benefits will not be available to you while you are collecting Plan benefits.

Contact Information

If you need answers to specific coverage related questions, contact the Benefits Source by going to their website or using their automated telephone system. Both the website and the automated telephone system can connect you with the Claims Administrator (if necessary).

Coverage Option	Contact
Short-Term Disability Plan	ESIS mysourceforhr.com (link to **ESIS.com**) 1-888-640-3320 (Benefits Source) You can connect with the Claims Administrator by phone via the Benefits Source automated telephone system.

General Plan Information

Program Name	NiSource Welfare Benefits Program
Plan Name:	NiSource Short-Term Disability Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Short-Term Disability
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions, and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5539
EIN:	35-2108964
Plan Year:	January 1 through Decmber 31
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under the Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., the Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	ESIS Two Riverway Suite 1100 Houston, Texas 77056
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Long-Term Disability Plan

Basic LTD Coverage

Supplemental LTD Coverage

Your Long-Term Disability Options

NiSource Inc. (the "Company") offers the NiSource Long-Term Disability Plan (the "Plan") to eligible employees with the following coverage options:

- Basic LTD Coverage Option; and
- Supplemental LTD Coverage Option.

Benefits are provided under a group insurance contract (the "Group Contract") and a group insurance certificate (the "Group Insurance Certificate") issued by The Prudential Insurance Company of America ("Prudential"), who is the Claims Administrator and is wholly responsible for the payment of benefits.

You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description. *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at 1-888-640-3320.*

The Plan provides financial protection for you by paying a portion of your income while you have a long period of disability. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits begin after the elimination period is completed. The elimination period is the period of continuous disability that must be satisfied before you are eligible to receive benefits and is the longest of (i) 180 days; (ii) the length of time for which you receive loss of time benefits, salary continuation or accumulated sick leave; and (iii) the date that you are absent from work for 1040 hours due to your disability.

If you are determined to be disabled, the Basic LTD Coverage Option provides monthly benefits of the lesser of (i) 50% of your monthly earnings, not reduced by any deductible sources of income, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $8,333.00.

If you are determined to be disabled, the Supplemental LTD Coverage Option provides monthly benefits of the lesser of (i) 60% of your monthly earnings, not reduced by any deductible sources of income, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $10,000.00. You pay a portion of the cost of the Supplemental LTD Coverage Option.

Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under the Plan. See *"Taxability of Monthly Benefits"* below for information regarding the taxability of monthly benefits you receive under the Plan. Refer to the Group Insurance Certificate for further details.

See "*Highlights of the Long-Term Disability Plan Coverage*" below for examples illustrating the payment of monthly benefits.

Eligibility

For information regarding eligibility under the Long-Term Disability Plan, please see the *"Eligibility under the Long-Term Disability Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Long-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Long-Term Disability Plan"*.

Contributions

The Basic LTD Coverage Option is provided at no cost to you. If you elect the Supplemental LTD Coverage Option, you and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. *If you have questions regarding the amount of your required contributions, please contact the Benefits Source at* ***1-888-640-3320****.*

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Long-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends –Long-Term Disability Plan"*.

Highlights of the Long-Term Disability Plan Coverage

The information below describes how the Plan pays benefits if a participant becomes disabled and is unable to work and when a participant becomes disabled, but continues working. See *"Taxability of Monthly Benefits"* below for information regarding the taxability of monthly benefits you receive under the Plan.

If you are Disabled and Not Working

If you have the Basic LTD Coverage Option, your Monthly Payment is the lesser of:

- 50% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $8,333.00 per month.

If you have elected the Supplemental LTD Coverage Option, your monthly payment is the lesser of:

- 60% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $10,000.00 per month

If You Are Disabled and Working

If your monthly disability earnings ("Disability Earnings") are less than 20% of your indexed monthly earnings ("Indexed Monthly Earnings"), your LTD benefit is the same as it would be if you were not working.

If your Disability Earnings are greater than 80% of your Indexed Monthly Earnings, no benefit is payable to you. If benefits have already commenced, Prudential will stop sending you payments and your claim will end.

If you are disabled and your monthly Disability earnings are at least 20%, but not more than 80%, of your Indexed Monthly Earnings, due to the same sickness or injury, Prudential will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as Disability Earnings plus the gross disability payment does not exceed 100% of Indexed Monthly Earnings.

1. Add your monthly Disability Earnings to your gross disability payment.

2. Compare the answer in item 1 to your Indexed Monthly Earnings.

If the answer from item 1 is less than or equal to 100% of your Indexed Monthly Earnings, Prudential will not further reduce your monthly payment.

If the answer from item 1 is more than 100% of your Indexed Monthly Earnings, Prudential will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your Disability.

1. Subtract your Disability Earnings from your Indexed Monthly Earnings.

2. Divide the answer in item 1 by your Indexed Monthly Earnings. This is your percentage of lost earnings.

3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

The minimum monthly payment is the greater of (a) 10% of the gross disability payment otherwise payable, and (b) $100.

If your Disability Earnings are expected to fluctuate widely from month to month, Prudential may average your Disability Earnings over the most recent 3 months to determine if your claim should continue subject to all other terms and conditions of the Plan. If Prudential averages your

Disability Earnings, it will terminate your claim if the average of your Disability Earnings form the last 3 months exceeds 80% of Indexed Monthly Earnings. Prudential will not pay you for any month during which Disability Earnings exceed the foregoing amounts.

Definition of "Disability"

You are "disabled" when Prudential determines that:

- you are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury;
- you have a 20% or more loss in your monthly earnings due to that sickness or injury; and
- you are under the regular care of a doctor.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury,

- you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and
- you are under the regular care of a doctor.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received by Prudential within 30 days of its request.

Prudential may require you to be examined by doctors, other medical practitioners or vocational experts of its choice. It will pay for these examinations. Prudential can require examinations as often as it is reasonable to do so. It may also require you to be interviewed by an authorized Prudential Representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Additional Definitions

Active employment means you are classified as working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least 40 hours per week. Your worksite must be: your Employer's usual place of business; an alternate worksite at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or a location to which your job requires you to travel. Normal vacation is considered active employment. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Deductible sources of income means income from deductible sources listed in the Group Insurance Certificate that you receive or are entitled to receive while you are disabled. This income may be subtracted from your gross disability payment. Examples of deductible sources of income include but are not limited to (a) amounts you receive or are entitled to receive as (i) loss of time benefits under a workers' compensation law, an occupational disease law or any other act or law with similar intent; or (ii) loss of time disability income payments under any state compulsory benefit act or law, any insurance, health or welfare plan or other group insurance plan where the Employer, directly or indirectly, has paid all or part of the cost or made payroll deductions, or any governmental retirement system as a result of your job with your Employer; (b) the gross amount you receive or are entitled to receive as loss of time disability payments because of your disability under the United States Social Security Act or any similar plan or act; (c) the gross amount you receive as retirement payments under the United States Social Security Act or any similar plan or act; (d) the amount your receive as "wages" under the maritime doctrine of maintenance, wages and cure; and (e) the amount you receive, due to your disability, from a third party (after subtracting attorneys' fees and a pro-rata share of reasonable fees and costs) by judgement, settlement or otherwise. Refer to

the Group Insurance Certificate for a complete list of these sources.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations: (i) during the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation, that is reasonably available; and (ii) beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience. Salary continuance paid to supplement your disability earnings will not be included as disability earnings because it is not payment for work performed.

Gainful occupation means an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 50% of your monthly earnings, if you are not working. However, if you enrolled in the Supplemental LTD Coverage Option, it means an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 60% of your monthly earnings, if you are not working

Gross disability payment means the benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1, provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Injury means a bodily injury that is the direct result of an accident, that is not related to any other cause, and that results in immediate disability. Disability must begin while you are covered under the Plan.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, Prudential will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Monthly earnings means your total annual income before taxes divided by 12. It is determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer. Commissions will be averaged for the lesser of: (a) the 24 full calendar month period of your employment with your Participating Employer just prior to the date disability begins; or (b) the period of actual employment with your Employer.

Regular occupation means the occupation you are routinely performing when your disability occurs. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the Plan.

Taxability of Monthly Benefits

Because your Employer pays the entire cost of your Basic LTD Coverage and does not include this cost in your gross-income, and because you pay for any Supplemental LTD Coverage

on a pre-tax basis, any monthly benefits you receive under the Plan will be taxable to you pursuant to the Code and guidance issued thereunder.

Maximum Period of Payments

The longest period of time the Plan will make payments to you for any one period of disability (your "maximum period of payment") is as follows:

Your Age on Date Disability Begins	Your Maximum Period of Payment
Less than 60	To age 65
Age 60 and over	60 months

Prudential will stop sending you payments while you are incarcerated as a result of a conviction.

In addition, Prudential will stop sending you payments and your claim will end on the earliest of the following:

- During the first 24 months of payments, when you are able to work in your regular occupation on a "part-time basis" but you choose not to; after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to. "Part-time basis" means the ability to work and earn 20% or more of your indexed monthly earnings.
- The end of the maximum period of payment.
- The date you are no longer disabled under the terms of the Plan.
- The date you fail to submit proof of continuing disability satisfactory to Prudential.
- The date your disability earnings exceed the amount allowable under the Plan.
- The date you retire.
- The date you die.
- The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by your doctor.

Notwithstanding the above, disabilities due to a sickness or injury which, as determined by Prudential, are primarily based on self-reported symptoms have a limited pay period during your lifetime. "Self-reported symptoms" means the manifestations of your condition, which you tell your doctor, that are not verifiable using tests, procedures and clinical examinations standardly accepted in the practice of medicine. Examples include, without limitation, headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Also, disabilities which, as determined by Prudential, are due in whole or part to mental illness also have a limited pay period during your lifetime. "Mental illness" means a psychiatric or psychological condition regardless of cause and includes, without limitation, schizophrenia, depression, manic depressive, or bipolar illness, anxiety, somatization, substance related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

The limited pay period for self-reported symptoms and mental illness combined is 24 months during your lifetime. There are exceptions to the limited pay period rules. Refer to the Group Insurance Certificate for a detailed explanation of these exceptions.

Recurrent Disabilities

If you have a "recurrent disability," as determined by Prudential, your disability will be treated as part of your prior claim and you will not have to complete another elimination period if (a) you were continuously insured under the Plan for the period between your prior claim and your current disability; and (b) your recurrent disability occurs within 180 days of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the Plan as your prior claim.

Any disability which occurs after 180 days from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the Plan provisions.

If you become covered under any other group long term disability plan, you will not be eligible for payments under the Plan.

A "recurrent disability" is a disability that is (a) caused by a worsening in your condition; and (b) due to the same cause(s) as your prior disability for which the Plan made a Long Term Disability payment.

Exclusions from Coverage

The Plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot; or
- commission of a crime for which you have been convicted under state or federal law.

The Plan does not cover a disability which is due to a pre-existing condition.

The plan does not cover a disability due to war, declared or undeclared, or any act of war.

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available; and
- Your disability begins within 12 months of the date your coverage under the Plan becomes effective.

Pre-existing conditions may also affect an increase in your benefits due to an amendment of the Plan or your enrollment in another Plan option. *For further details, refer to the Group Insurance Certificate. You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

Survivor Benefits

When Prudential receives proof that you have died, it will pay your spouse, if living; otherwise, your children under age 25 (your "eligible survivors"), a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. However, Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

Other Services Provided Under the Plan

As part of your coverage under the Plan, Prudential also provides certain benefits in the nature of a Social Security Claimant Assistance Program, a Rehabilitation Program and a program of reimbursing employers for the cost of certain worksite modifications that are identified by your Employer and Prudential as being likely to help you remain at work or return to work. Refer to the Group Insurance Certificate for further details regarding these programs. With respect to the Rehabilitation Program, if at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease paying your monthly benefit.

Filing A Claim

General

Written notice of a claim should be sent to Prudential within 30 days after the date your disability begins. However, you must send Prudential written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than

1 year after the time proof is otherwise required except in the absence of legal capacity. You must notify us immediately when you return to work in any capacity.

*Claim forms can be obtained from Prudential by phone via the Benefits Source at **1-888-640-3320**, or online via the Benefits Source website at mysourceforhr.com. If you do not receive the form from Prudential within 15 days of your request, send Prudential written proof of claim without waiting for the form.*

How to File Claims

You and your Employer must fill out your own section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and send it directly to Prudential.

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a doctor.
- Appropriate documentation of your monthly earnings.
- The date your disability began.
- Appropriate documentation of the disabling disorder.
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation.
- The name and address of any hospital or institution where you received treatment, including all attending doctors.
- The name and address of any doctor you have seen.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by Prudential.

In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by Prudential. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.

Recovery of Overpayments

Prudential has the right to recover any overpayments due to (i) fraud; (ii) any error Prudential makes in processing a claim, and (iii) your receipt of deductible sources of income.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Long-Term Disability Plan."*

Continuation of Other Coverages

Certain coverages provided to you under the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program continue while you are Disabled and receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee. Any contributions that you are required to make toward the cost of these coverages will be billed to you. For further information regarding the billing arrangement, contact the Benefits Source.

Medical, Prescription Drug, Vision and Dental
Medical, vision and dental coverages for you and your eligible dependents continue while you are receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Life and AD&D
Life and AD&D coverages for you and your eligible dependents continue while you are

receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Health Care Flexible Spending Account

Your Health Care FSA coverage continues while you are receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee.

Dependent Care Flexible Spending Account

You cannot continue to make contributions to the Dependent Care FSA while you are receiving Plan benefits. You may use the existing balance in your account to pay for any eligible expense that you incurred prior to the commencement of your Plan benefits.

HSAs

You may receive an Employer contribution to your HSA if you are enrolled in an HDPPO coverage option and are otherwise eligible to contribute to a Health Savings Account. You may also contribute to your HSA while you are receiving Plan benefits; however your contribution may not be funded out of your Plan benefit payments.

Retirement Plans

While you are receiving Plan benefits, you may continue to earn service under your retirement plans. However, your contributions to the Savings Plan automatically stop. You are eligible to receive the value of your Savings Plan Account due to your disability. Refer to the Savings Plan and your other retirement plans for further information.

Other Programs

The Adoption Assistance and the Tuition Reimbursement Programs are not available to you while you are receiving Plan benefits.

Important Information For Residents Of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and in this summary plan description. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this summary plan description. Prudential has a website that describes these state-specific requirements. You may access the website at prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 93191.

If you are unable to access this website, and if you want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Long-Term Disability Plan (a component of NiSource Welfare Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing disability benefits
Plan Number:	537
Contribution Source:	Basic LTD Coverage: Employer Supplemental LTD Coverage: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102
Claims Administrator: (if you need to submit a claim)	The Prudential Insurance Company of America Prudential Disability Management Services P.O. Box 13480 Philadelphia, Pennsylvania 19176
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. ***In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail***. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

The Prudential Insurance Company of America, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Life and AD&D Plan

Employee Term Life Coverage – Basic and Optional Plans

Dependents Term Life Coverage

Employee AD&D Coverage – Basic and Supplemental Plans

Dependents AD&D Coverage

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Optional Employee Term Life Coverage Option;
- Dependents Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;
- Supplemental Employee AD&D Coverage Option; and
- Dependents AD&D Coverage Option

The Life and AD&D Coverage Options other than the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option are referred to collectively as the "Optional Life and AD&D Coverage Options."

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance") and, if elected, on the persons of your "eligible dependents" ("Dependents Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option. If you elect coverage under any of the Optional Life and AD&D Coverage Options, you will pay for the cost of such coverage. *If you have questions regarding the amount of your required contributions, please contact the Benefits Source at **1-888-640-3320**.*

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and

AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in an amount up to two times (2x) your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. If you are also enrolled in Optional Employee Term Life Coverage, the amount of your Basic Employee Term Life Coverage will be added to your Optional Term Life Coverage before rounding takes place. The maximum benefit (for Basic and Optional Employee Term Life Coverage combined) is $1,500,000. Amounts otherwise payable as benefits will be reduced by the amount of any Accelerated Benefits paid under the Option to Accelerate Payment of Death Benefits.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 58.

Optional Employee Term Life Coverage

You may enroll in one of the options below for optional term life coverage.

Benefit Classes	Amount of Insurance (Multiple of Annual Earnings)	
	Sum of Basic + Optional	Optional
Option 1	3x annual Earnings	1x annual Earnings
Option 2	4x annual Earnings	2x annual Earnings
Option 3	5x annual Earnings	3x annual Earnings
Option 4	6x annual Earnings	4x annual Earnings
Option 5	7x annual Earnings	5x annual Earnings

If the amount of your Basic Employee Term Life Coverage, when added to the amount of your Optional Employee Term Life Coverage, is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. However, the maximum benefit for Basic and Optional Employee Term Life Coverage combined is $1,500,000. Amounts otherwise payable as benefits will be reduced by the amount of any Accelerated Benefits paid under the Option to Accelerate Payment of Death Benefits.

Any requested change in coverage (increase or decrease) must be made within 31 days of a qualified life event or in connection with annual enrollment.

Notwithstanding the foregoing, the amount of your coverage may not exceed the "guaranteed issue amount" unless you submit evidence of insurability that is satisfactory to Securian and you are actively at work. The "guaranteed issue amount" is the lesser of (1) three times (3x) your annual Earnings, and (2) $500,000. Also, you must submit evidence of insurability if you are first applying for coverage under the Optional Employee Term Life Coverage Option during annual enrollment and your application is made more than 31 days after the date you first became eligible for coverage.

Without limiting the generality of the foregoing, you will need to provide evidence of insurability

- If you are a regular new hire or newly eligible for coverage and you apply for coverage under the Optional Employee Term Life Coverage Option in an amount greater than three times (3x) your annual Earnings (Basic plus Optional Coverage combined), or if the total amount of your Term Life Coverage after giving effect to your Optional Employee Term Life Coverage exceeds $500,000;
- If you are first applying for coverage under the Optional Employee Term Life Coverage Option during annual enrollment and the date you apply during annual enrollment is more than 31 days after your date of hire or the date you newly became eligible for coverage;
- If you are currently enrolled in the Optional Employee Term Life Coverage Option, you want to increase your coverage during annual enrollment, and the amount of your requested increase is greater than one times (1x) your annual Earnings, or the total amount of your Term Life Coverage after giving effect to your requested increase in coverage exceeds $500,000;
- If you request an increase in coverage due to a qualified life event and the amount of your requested increase is greater than one times (1x) your annual Earnings, or the total amount of your combined coverage under the Basic Employee Term Life Coverage Option and the Optional Employee Term Life Coverage Option (your "Employee Term Life Insurance") after giving effect to your requested increase in coverage exceeds $500,000;
- If you desire life insurance coverage and have an individual life insurance contract you obtained by converting your coverage under the Plan;
- The insurance for which you previously enrolled did not go into effect or was terminated because you failed to make a required premium contribution; and
- If you have not met a previous evidence requirement to become insured under any plan a Participating Employer has with Securian.

Any new enrollment or requested increase in coverage that is subject to evidence of insurability will become effective when Securian decides the evidence is satisfactory and you are actively at work; provided, however, that any such new enrollment or requested increase in coverage that is made in connection with annual enrollment will be effective on the later of (1) the following January 1, and (2) the first day of the month following the date Securian decides the evidence is satisfactory and you are actively at work.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any

lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 58.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option or the Optional Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor.

The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000. The maximum death benefit eligible for an Accelerated Benefit is $1,000,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

If you elect an Accelerated Benefit and the termination of your Employee Term Life Insurance causes an eligible dependent to lose life insurance coverage, he or she will be allowed to convert any such insurance to a policy of individual life insurance as discussed below under the section entitled "Conversion Privilege for Life Coverage."

If the amount of your Employee Term Life Insurance exceeds the maximum Accelerated Benefit, your Employee Term Life Insurance coverage (reduced by the amount of the Accelerated Benefit) will continue after your election of the Accelerated Benefit and your premiums will be reduced accordingly. The amount of the Accelerated Benefit will be applied first to reduce your outstanding Optional Employee Term Life Coverage and

then to reduce your outstanding Basic Employee Term Life Coverage.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Dependents Term Life Coverage

Under the Dependents Term Life Coverage Option, you may enroll your "eligible dependents" for coverage in the amounts shown below.

Your spouse who is an "eligible dependent"	
Benefit Classes	**Amount of Insurance**
Option 1	$10,000
Option 2	$25,000
Option 3	$50,000

Your children who are "eligible dependents"	
Benefit Classes	**Amount of Insurance***
Option 1	$5,000
Option 2	$10,000

You must provide evidence of insurability under the following circumstances:

- If you choose Option 3 spousal coverage (coverage in the amount of $50,000);
- If any dependent's coverage for which you previously enrolled did not go into effect under the Plan or was terminated because you did not pay a required contribution;
- If, during a previous period of eligibility, you failed to submit evidence of insurability that was required for a dependent or that which was submitted was not satisfactory to Securian; or
- Your dependent is insured by an individual policy issued under the terms of the conversion right.

Option 3 spousal coverage will become effective on the date Securian decides the evidence of insurability is satisfactory.

If a dependent (other than a newborn child) is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released form such hospitalization or confinement.

No enrollment or increases in coverage may become effective so long as your "eligible dependents" are confined for medical care or treatment, whether at home or elsewhere.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 58.

Payment of Death Benefits under Life Coverage

If you or your "eligible dependent" dies while covered under the Plan, the amount of insurance on you or your "eligible dependent" is payable when Securian's home office receives written proof satisfactory to it that you or your eligible dependent died while covered under the Plan and insured under the Group Insurance Certificate. If you or an "eligible dependent" die within 31 days after ceasing to be covered under the Plan, but while you or your "eligible dependent,"

as the case may be, are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules. Death benefits under the Dependents Term Life Coverage Option are payable to you, if you are living. If you are not living, benefits are payable to your estate.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance or your coverage under the Dependents Term Life Coverage Option terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features"* below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in an amount up to two times (2x) your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit (for Basic and Supplemental Employee AD&D Coverage combined) is $1,500,000.

Supplemental Employee AD&D Coverage Option

You may enroll for supplemental employee AD&D coverage in any multiple of $10,000 up to the lesser of (1) ten times your annual Earnings, and (2) $1,500,000 minus the amount of your insurance under the Basic Employee AD&D Coverage Option).

Dependents AD&D Coverage Option

You may enroll for AD&D coverage on each of your "eligible dependents" in an amount equal to a percentage of your Supplemental Employee AD&D Coverage, as set forth below:

Eligible dependents	Amount of Insurance on each Eligible Dependent (as % of Employee AD&D Coverage)
Spouse only	60% on spouse
Child(ren) only	10% on each child
Spouse and child(ren)	50% on spouse; 10% on each child

Additional AD&D Coverage

The Plan provides additional benefits under the Basic, Supplemental Employee, and Dependents AD&D Coverage Options for a person's loss of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance on the person, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including

Reserve or National Guard active duty for training); (8) travel in or descent from any aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 58.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance and the Dependents Term Life Coverage Option, except that you or your "eligible dependent," as the case may be, may convert the amount of insurance under the Employee Term Life Insurance or the Dependents Term Life Coverage Option that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You and your eligible dependents are eligible to continue your Employee Insurance and Dependents Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date, but not more than $1,000,000 for an employee or $50,000 for a spouse. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date to a maximum of $650,000 for an employee or $32,500 for a spouse.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000. This minimum does not apply to a dependent.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) in the case of your dependent child or a spouse who is covered under the Plan, the date your coverage is no longer being continued under the Portability Plan or the date your spouse or child ceases to be eligible under the Plan; or

(4) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life, Optional Life, Dependent Life, be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No. except for conversion of Dependent Life	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

*Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at **1-888-640-3320**, or online via the Benefits Source website at* mysourceforhr.com*. If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process –Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Exempt Part-Time Employees Hired or Rehired Before January 1, 2010

Contents

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular part-time exempt employees hired or rehired before January 1, 2010 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 105.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – Pension and 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement

under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program**

Overview and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Safety Plan Rehire" means (i) a person eligible for retiree medical and retiree life insurance benefits who is rehired by Columbia Gas of Ohio, Inc. after January 1, 2019 to support the construction activities associated with regulator station replacement in conjunction with the LP-Enhanced Safety Plan and natural gas system replacement projects, or (ii) a retiree who was rehired by Bay State Gas Company after January 1, 2019 for a short-term position as Department of Public Utilities liaison for the third-party audit of post-incident construction.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note: It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be

denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues, and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether*

you are eligible to participate in the Medical, Dental or Vision Plan.

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year, you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months prior to the month in which you apply for benefits, but not earlier than the first month you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits*

*Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular part-time employee of a Participating Employer, (ii) regularly work less than 40 hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, and vision coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO coverage under the Medical Plan), basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

> **Please Note:**
>
> Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you

may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (collectively referred to as "Employee Life and AD&D Insurance").

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a

participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your child(ren) under the same plan. Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Special Rule for Rehired Employees

If you terminate employment and are rehired after your termination date, the benefit elections that were in effect on the date of your termination **will not be** automatically reinstated. You will need to re-elect coverages once you again become eligible upon your return.

Upon your rehire, you will be no longer be entitled to benefits under Active Benefit Program 105, but will instead designated as being entitled to the Active Benefit Program applicable to similarly situated eligible employees hired as of the date of your rehire. In addition, unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , as a rehired employee, you will not be entitled to any retiree medical or retiree life insurance benefits upon your retirement or other termination of employment.

Special Rule for Certain Employment Transfers

If you were hired or rehired on or after January 1, 2010, and you thereafter transfer to an "exempt employee" status, you will not be eligible for retiree medical or retiree life insurance benefits upon your retirement or other termination of employment. An "exempt employee" includes a non-union employee (an employee whose employment is not subject to the terms of a collective bargaining agreement) and an employee who is not entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. §201, et seq.

This special rule does not apply to a Safety Plan Rehire, to the extent such Safety Plan Rehire is not thereafter rehired by an Employer or transferred to another employee status.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates. You will be advised of any new benefit plans,

plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;

- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage"* for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;
- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day.

If you are not actively at work on the date coverage would otherwise begin, you will not be eligible for the coverage until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Coverage Ends

Your Employee Life and AD&D Insurance will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D Coverage Option, the date such Life and AD&D Coverage Option is terminated;
- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular part-time employee or as a member of another eligible class;

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active part-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, or the Flexible Benefits Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all

requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical

Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***

- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

In the case of a divorce or separation, the following order will establish responsibility for payment:

— If there is a court order that requires a parent to take financial responsibility for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.

— The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.

— If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.

— The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-

eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits, the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse

benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the

circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;
- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your

receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to

request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;

- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective

review, were covered under the Plan at the time the health care item or service was provided;

- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the

criteria are inconsistent with the terms of the Plan or with applicable law;

- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has

not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

- Your name;
- The date(s) of the medical service;
- The specific medical condition or symptom;
- The provider's name
- The service or supply for which approval of benefits was sought; and

- Any reasons why the appeal should be processed on a more expedited basis.

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or

comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to

contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request

for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D

Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a

claim and an explanation of why such information is necessary, and

- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a

notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its

discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan. Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." The leaves referred to above are:

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account

of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage

does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care FSA, you may continue your current contributions to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another

qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to provide any group health plan or coverage to any employee.
- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under

ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at dol.gov/ebsa (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);

- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you

use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice

President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may

have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Benefit Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Benefit Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Benefit Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is

denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Medical Coverage for Retirees

You may be eligible for medical benefits as a retired employee if you meet certain eligibility requirements. For further information about your eligibility for medical benefits as a retired employee or to notify the Company or your Employer of your retirement, contact the Benefits Source at **1-888-640-3320**.

Unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , if you retire or otherwise terminate employment and are later rehired by the Company, a Participating Employer, or any of their affiliates, you will not be eligible for retiree medical or retiree life insurance benefits, including after your subsequent retirement or other termination of employment.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan

benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible[†]	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

[†]Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	Out-of-Network
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

	HDPPO 1		HDPPO 2	
FEATURE	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$3,000	$6,000	$5,000	$10,000

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at 1-888-640-3320 for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

TYPE OF SERVICE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers,

distributors, and/or similar vendors, which may be related to certain prescription drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 29.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and

  - Prescribed medications (Outpatient prescription drug services are covered under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).
- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;

  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam and one hearing aid per ear during a two calendar-year period; and
- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational

therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;
- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance,

when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

  See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age,

gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

  See the following website for additional information:
  https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;

- Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);
- Screening for gestational diabetes;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

- Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

- Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
- Inpatient covered hospital services related to the transplant procedure.
- Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay*
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

***Please Note**:* Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Preventive Dental

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 35.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 35.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA Features	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. *A non-exhaustive list of eligible expenses can be found later in this section.*
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A non-exhaustive list of eligible expenses can be found later in this section.*

FSA Features	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 35.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;

- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;

- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website **mysourceforhr.com**.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 36.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax*

purposes. Please consult your tax advisor for more information.

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out

of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Life and AD&D Plan

Employee Term Life Coverage – Basic Plan

Employee AD&D Coverage – Basic Plan

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at* ***1-888-640-3320****.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in the amount of $20,000.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor. The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Payment of Death Benefits under Life Coverage

If you die while covered under the Plan, the amount of insurance on you is payable when Securian's home office receives written proof satisfactory to it that you died while covered under the Plan and insured under the Group Insurance Certificate. If you die within 31 days after ceasing to be covered under the Plan, but while you are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features*" below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in the amount of $20,000.

Additional AD&D Coverage

The Plan provides additional benefits under the Basic AD&D Coverage Option for your loss of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including

Reserve or National Guard active duty for training); (8) travel in or descent from any aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance, except that you may convert the amount of insurance under the Employee Term Life Insurance that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You are eligible to continue your Employee Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by

Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at ***1-888-640-3320****, or online via the Benefits Source website at* mysourceforhr.com*. If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Exempt Full-Time Employees Hired or Rehired Before January 1, 2010

Contents

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular full-time exempt employees hired or rehired before January 1, 2010 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 104.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Travel Accident Coverage (NiSource Travel Accident Plan – referred to as the "Travel Accident Plan")
- Short-Term Disability Coverage (NiSource Short-Term Disability Plan –

referred to as the "Short-Term Disability Plan")

- Long-Term Disability Coverage (NiSource Long-Term Disability Plan – referred to as the "Long-Term Disability Plan")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – Pension and 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the

applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a

person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview** and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Safety Plan Rehire" means (i) a person eligible for retiree medical and retiree life insurance benefits who is rehired by Columbia Gas of Ohio, Inc. after January 1, 2019 to support the construction activities associated with regulator station replacement in conjunction with the LP-Enhanced Safety Plan and natural gas system replacement projects, or (ii) a retiree who was rehired by Bay State Gas Company after January 1, 2019 for a short-term position as Department of Public Utilities liaison for the third-party audit of post-incident construction.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note: It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a

Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues; and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance,

legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at **mysourceforhr.com**, *or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Medical, Dental or Vision Plan.*

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year, you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular full-time employee of a Participating Employer who regularly works 40 or more hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months prior to the month in which you apply for benefits, but not earlier than the first month

you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Travel Accident Plan

If you are classified as a full-time employee, you will be eligible to participate in the Travel Accident Plan as of your first day of active, full-time employment with a Participating Employer. You are a "full-time employee" if you are characterized by your Employer as a full-time employee who regularly works 40 or more hours per week.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Travel Accident Plan.*

Eligibility under the Short-Term Disability Plan

If you are a full-time employee, you will be covered under the Short-Term Disability Plan as of the first day of the month coincident with or next following your completion of six continuous months of active, full-time employment with a Participating Employer. You are a "full-time employee" if you are characterized by your Employer as a full-time employee who regularly works 40 hours per week. Newly hired employees must be actively at work on the date coverage is scheduled to begin.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Short-Term Disability Plan.*

Eligibility under the Long-Term Disability Plan

You are eligible to participate in the Long-Term Disability Plan if you are a regular full-time employee of a Participating Employer who works 40 or more hours per week and are in active employment. You are in active employment if you are working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. Your worksite must be your Employer's usual place of business, an alternate work site at the direction of your Employer other than your home, unless clear specific expectations and duties are documented, or a location to which your job requires you to travel. Your eligibility for optional, contributory coverage may be subject to your satisfying other requirements established by Prudential Insurance Company of America. Refer to the group insurance certificate issued by Prudential for more details.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Long-Term Disability Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular full-time employee of a Participating Employer, (ii) regularly work 40 or more hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff,

subject to your Employer's practices and procedures.

Your eligibility for optional, contributory coverage may be subject to your providing evidence of insurability and satisfying other requirements established by the insurer, Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc.

See the Life and AD&D Benefit Plan section below and refer to the group insurance certificate issued by Securian for further details.

Eligible Dependents

If you are eligible to participate in the Life and AD&D Plan, you may obtain certain coverage for your "eligible dependents." Your "eligible dependents" are:

- Your lawful Spouse, provided you are not legally separated; and
- Your unmarried children from live birth to the end of the month in which the unmarried child attains age 26; and

Your "children" include: (1) your natural children, legally adopted children and children placed with you for adoption prior to legal adoption; and (2) each of your stepchildren, foster children, children subject to legal guardianship, grandchildren, and other children who are blood relatives who depend on you for more than fifty percent of their support and maintenance. A child placed with you for adoption prior to legal adoption is considered an eligible dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

Notwithstanding the foregoing, your unmarried children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on you for more than 50% of their support and maintenance.

Also notwithstanding the foregoing,

(1) Your spouse is not your "eligible dependent" while on active duty in the armed forces of any country; and

(2) Your child is not your "eligible dependent" while (a) on active duty in the armed forces of any country; or (b) insured under any Employee Insurance.

A child will not be considered the "eligible dependent" of more than one employee. If this would otherwise be the case, the child will be considered the "eligible dependent" of the employee named in a written agreement of all such employees filed with the Company. If there is no written agreement, the child will be considered the "eligible dependent" of:

(1) the employee who became insured under the Plan with respect to the child while the child was an "eligible dependent" of only that employee; and otherwise

(2) the employee who has the longest continuous service with a Participating Employer, based on the Company's records.

*Please refer to the Benefits Source website at mysourceforhr.com, or call the Benefits Source at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Life and AD&D Plan.*

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, vision, supplemental and dependent life and AD&D and supplemental long-term disability coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO

coverage under the Medical Plan), travel accident, short-term disability, basic long-term disability, basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.** To enroll in supplemental and dependent life and AD&D and supplemental long-term disability coverages, you must use enrollment forms approved by Securian (with respect to life and AD&D coverage) and Prudential (with respect to long-term disability coverage). You may obtain these enrollment forms by contacting the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

Please Note:

Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the

amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Travel Accident Plan

No affirmative enrollment is required for the Travel Accident Plan. You are automatically enrolled upon the date you become eligible for such coverage.

Enrollment in the Short-Term Disability Plan

No affirmative enrollment is required for the Short-Term Disability Plan. You are automatically enrolled upon the date you become eligible for such coverage.

Enrollment in the Long-Term Disability Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Long-Term Disability Plan*" section above, you will be automatically enrolled in the Basic LTD Coverage Option, unless you choose to enroll in the Supplemental LTD Coverage Option. Newly eligible employees must enroll in the Supplemental LTD Coverage Option within 31 days of their date of hire or, if later, the date they first become eligible for coverage. If you fail to enroll, you will automatically be covered under the Basic LTD Coverage Option. In general, once you enroll in (or decline) the Supplemental LTD Coverage Option, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.)

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (such Life and AD&D Coverage Options, together with the Optional Employee Term Life Coverage Option and the Supplemental Employee AD&D Coverage Option, are collectively referred to as "Employee Life and AD&D Insurance"). If you desire coverage under the Optional Employee Term Life Coverage Option, the Dependents Term Life Coverage Option, the Supplemental Employee AD&D Coverage Option, or the Dependents AD&D Coverage Option (collectively the "Optional Life and AD&D Coverage Options") as a newly eligible employee, you must enroll in such Optional Life and AD&D Coverage Option within 31 days of your date of hire or the

date you become newly eligible. If you do not enroll in an Optional Life and AD&D Coverage Option during this initial 31-day period, you may need to provide evidence of insurability if you decide to enroll at a later date. You must enroll using forms approved by Securian. *You may obtain forms for enrolling in, or changing, your Optional Life and AD&D Coverage Options by contacting the Benefits Source at* ***1-888-640-3320.***

In general, once you enroll in (or decline) any of the Optional Life and AD&D Coverage Options, your elections stay in effect for the entire Plan Year and can only be changed during annual enrollment. If you do not enroll or elect to change coverage, if applicable, during the annual enrollment period, your current coverage election will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing coverages during the Plan Year. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.) If any change in coverage is subject to evidence of insurability, Securian must decide that such evidence is satisfactory.

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your child(ren) under the same plan (e.g., child life insurance). Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Special Rule for Rehired Employees

If you terminate employment and are rehired after your termination date, the benefit elections that were in effect on the date of your termination **will not be** automatically

reinstated. You will need to re-elect coverages once you again become eligible upon your return.

Upon your rehire, you will no longer be entitled to benefits under Active Benefit Program 104, but will instead be designated as being entitled to the Active Benefit Program applicable to similarly situated eligible employees hired as of the date of your rehire. In addition, unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , as a rehired employee, you will not be entitled to any retiree medical or retiree life insurance benefits upon your retirement or other termination of employment.

Special Rule for Certain Employment Transfers

If you were hired or rehired on or after January 1, 2010, and you thereafter transfer to an "exempt employee" status, you will not be eligible for retiree medical or retiree life insurance benefits upon your retirement or other termination of employment. An "exempt employee" includes a non-union employee (an employee whose employment is not subject to the terms of a collective bargaining agreement) and an employee who is not entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. §201, et seq.

This special rule does not apply to a Safety Plan Rehire, to the extent such Safety Plan Rehire is not thereafter rehired by an Employer or transferred to another employee status.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates. You will be advised of any new benefit plans, plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

Opt-Out Credit

If you are a full-time employee and have coverage elsewhere and decline medical or dental coverage under the Medical or Dental Plans, you may be eligible for an opt-out credit, if available. Please refer to the enrollment material to see if this option is currently being offered. If you have declined coverage, but your Spouse or parent is also an employee or retiree and is covering you as a dependent, you are not entitled to an opt-out credit. If you are a covered dependent under the Medical and/or Dental Plans, you must call the Benefits Source at **1-888-640-3320** during enrollment to update your status. The Company will recover payment of ineligible opt-out credits through payroll deductions.

Please Note:

If you have declined Medical Plan coverage, but your Spouse or parent is also an employee or retiree who is covering you under the Medical Plan as a dependent, you are not entitled to an opt-out credit. You must call the Benefits Source at **1-888-640-3320** during enrollment to update your status.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage*" for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided

under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;

- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Travel Accident Plan

Coverage Begins

Your Travel Accident Plan coverage becomes effective on the first day of your active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Travel Accident Plan for benefits on the earliest of the following:

- The date as of which the Plan is terminated;
- The date that the Plan is amended to terminate your coverage;
- The date you are no longer eligible for coverage under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy; and
- The date you terminate employment.

When Coverage Begins and Ends – Short-Term Disability Plan

Coverage Begins

Your Short-Term Disability Plan coverage became effective on the first day of the month coincident with or next following the date you completed six continuous months of active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Short-Term Disability Plan for benefits on the earliest of the following:

- The date the Plan is terminated;

- The effective date of any Plan amendment that terminates coverage with respect to you;
- The date you are no longer eligible for coverage under the Plan, including without limitation as a result of your Employer no longer being affiliated with the Company or no longer being a Participating Employer in the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994;
- The last day for which you made any required contribution toward the cost of Plan coverage;
- The date you begin any leave of absence; and
- The date your employment terminates.

When Coverage Begins and Ends – Long-Term Disability Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Long-Term Disability Plan,"* coverage under the Basic LTD Coverage Option of the Long-Term Disability Plan generally may become effective on the later of (1) your first day of active employment, for regular new hires, (2) the day you become a member of a class eligible for coverage under the Plan, (3) the first day of the following Plan Year, for eligible employees who choose not to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period, or (4) the date the Plan approves such enrollment, for employees who disenroll from the Supplemental LTD Coverage Option due to a qualified life event.

Coverage under the Supplemental LTD Coverage Option generally may become effective on the later of (1) the date you are eligible for coverage, if you enroll on or before that date; (2) the date you enroll for coverage, if you enroll within 31 days after the date you are eligible for coverage; (3) the date Prudential approves your application, if evidence of insurability is required; (4) the date you are in active employment; (5) the first day of the following Plan Year, for eligible employees who choose to reenroll in the Supplemental LTD Coverage Option during the annual enrollment period; or (6) the date the Plan approves such enrollment due to a qualified life event.

Evidence of insurability means a statement of your medical history that Prudential will use to determine if you are approved for coverage. You must give evidence of insurability, at your expense, if (1) you enroll for coverage more than 31 days after the date you are eligible for it; (2) you re-enroll for coverage after you voluntarily cancelled it; (3) you enroll after any coverage ends because you did not pay a required contribution; or (4) you have not met a previous evidence requirement to become covered under any plan NiSource has with Prudential. Prudential will decide when evidence of insurability is satisfactory.

Once your coverage begins, any increased or additional coverage will take effect on the latest of: (1) the effective date of the change, if you are in active employment, on a temporary layoff, on leave of absence, or working reduced hours (for reasons other than disability); (2) the date Prudential approves your application, if evidence of insurability is required; or (3) the date you return to active employment, if you are not in active employment due to injury or sickness.

Coverage Ends

Your coverage under the Long-Term Disability Plan will end on the date you lose eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the group insurance contract issued by The Prudential Insurance Company of America is canceled;
- The date that the Plan is amended to terminate your coverage;

- The date you terminate employment or are no longer eligible for coverage under the Plan;
- The date you are no longer in active employment due to a disability that is not covered under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made; or
- The date you are no longer in active employment, except as provided below and except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 ("FMLA").

If you are on a temporary layoff or are working reduced hours for reasons other than disability and the premium is paid, you will be covered to the end of the month following the month in which your temporary layoff or reduced hours begin. If you are on a leave of absence and the premium is paid, you will be covered to the end of the month in which your leave begins. Neither temporary layoff nor leave of absence includes normal vacation time or any period of disability or absence in connection with any severance or termination agreement. Your FMLA leave also is not considered a temporary layoff.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day.

Provided you have satisfied the eligibility requirements described above, coverage under the Employee Optional Life and AD&D Coverage Options may generally become effective on the first day on which each of the following conditions are met: (1) you have enrolled for coverage, including, if required, applying for coverage on forms approved by the Claims Administrator, (2) with respect to the Optional Employee Term Life Coverage Option, the Claims Administrator is satisfied with your evidence of insurability, if evidence is required (provided that coverage will become effective as of the first day of the month following the Claims Administrator's determination that evidence is satisfactory), and (3) the Claims Administrator has received the required premium.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Provided you have satisfied the eligibility requirements described above, coverage of your "eligible dependents" under the Dependents Term Life Coverage Option and the Dependents AD&D Coverage Option ("Dependents Life and AD&D Insurance") generally may become effective on the first day on which each of the following conditions are met: (1) you have enrolled for dependent coverage, including, if required, applying for coverage on forms approved by the Claims Administrator, (2) the person to be covered is your "eligible dependent", (3) you are insured for employee coverage under the particular coverage sought (e.g., for the Dependents Term Life Coverage Option, you are covered under the Basic Employee Term

Life Coverage Option, and for the Dependents AD&D Coverage Option, you are covered under the Supplemental Employee AD&D Coverage Option), (4) for the Dependents Term Life Coverage Option, the Claims Administrator is satisfied with your eligible dependent's evidence of insurability, if evidence is required, and (5) the Claims Administrator has received the required premium.

If an eligible dependent (other than a newborn child) is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement.

Evidence of your insurability may be required under certain circumstances if you apply for coverage under the Optional Employee Term Life Coverage Option. Evidence of your eligible dependent's insurability may also be required under certain circumstances if you apply for coverage for your eligible dependent under the Dependents Term Life Coverage Option. See the sections in the Life and AD&D Benefits Plan section below entitled *"Optional Employee Term Life Coverage"* and *"Dependents Term Life Coverage"* for more details concerning evidence of insurability requirements.

If you apply for coverage that requires evidence of insurability, your coverage election will be autocorrected to the greatest amount of coverage, consistent with your election, to which you would otherwise be entitled without evidence of insurability. Once evidence of insurability is approved by Securian, your coverage will be updated effective the first of the month following approval (or, if later, January 1, in the case of an election made during annual enrollment).

Coverage Ends

Your Employee Life and AD&D Insurance or Dependents Life and AD&D Insurance under a Life and AD&D Coverage Option will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D Coverage Option, the date such Life and AD&D Coverage Option is terminated;
- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular full-time employee or as a member of another eligible class;
- For Life and AD&D Coverage Options that are contributory, 31 days after the due date of any required contribution that is not paid, provided that failure to contribute for Dependents Life and AD&D Insurance will not cause your Employee Life and AD&D Insurance to end;
- For the Dependents Term Life Coverage Option, the date your coverage under the Basic Employee Term Life Coverage Option ends;
- For the Dependents AD&D Coverage Option, the date your coverage under the Supplemental Employee AD&D Coverage Option ends;
- For Dependents Life and AD&D Insurance, the last day of the month in which your "eligible dependent" ceases to be an "eligible dependent" for the coverage or is no longer covered under the Group Contract.
- For coverage under an Employee Optional Life and AD&D Coverage Option, the last day for which premium contributions have been made following your written request to end coverage under such Employee Optional Life and AD&D Coverage Option.
- For Dependents Life and AD&D Insurance, the last day for which premium contributions have been made following your written request to end Dependents Life and AD&D Insurance for an "eligible dependent"

You must notify the Claims Administrator or the Benefits Source at **1-888-640-3320** when a dependent is no longer eligible for

coverage under the Life and AD&D Plan so that premiums may be discontinued. No claims will be paid under the Life and AD&D Plan in respect of an ineligible dependent.

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active full-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, the Flexible Benefits Plan, the Life and AD&D Plan or the Long-Term Disability Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.

- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***
- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday

Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

In the case of a divorce or separation, the following order will establish responsibility for payment:

- If there is a court order that requires a parent to take financial responsibility for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.
- The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.
- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.
- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may

not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits, the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations.

Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;
- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that

is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any

deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider

additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim.

Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that

takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA

following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as

used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your

duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Travel Accident Plan

The claim determination and appeal process described below applies to the Travel Accident Plan. As used in this section, (i) the term "Plan" refers to the Travel Accident Plan, and (ii) the term "Claims Administrator" refers to the NiSource Benefits Department or such other claims administrator appointed for the Plan. Any claim for benefits submitted after eighteen months from the date of a covered person's death may not be considered for payment.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

Within 90 days of receiving a claim, the Claims Administrator will provide your beneficiary with a written notice of its decision. If because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator Denies the Claim

If the Claims Administrator denies your beneficiary's claim in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the pertinent provisions in the Plan on which the denial is based;
- A description of any additional material or information necessary for your beneficiary to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals.

Appeal to Claims Administrator

If your beneficiary has a claim denied in whole or in part, your beneficiary has the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial.

Your beneficiary's request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Travel Accident Plan.

Your beneficiary may submit written comments, documents, records, and other information relating to the claim for benefits. Upon his or her request, your beneficiary will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Your beneficiary's written request should state why he or she thinks the claim should not have been denied. Your beneficiary's request also should include any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your beneficiary's request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by your beneficiary relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

Your beneficiary will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator Denies the Appeal

If the Claims Administrator denies your beneficiary's appeal in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A statement that your beneficiary is entitled to receive upon request and free of

charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits; and

- A statement indicating the beneficiary's right to file a lawsuit upon completion of the claims procedure process.

Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your beneficiary's claim on appeal, your beneficiary may file a written claim with the Plan Administrator within 60 days after your appeal has been denied in whole or in part by the Claims Administrator.

Any claim for benefits with the Plan Administrator will be processed within 60 days of its receipt unless additional time is required to process the claim, in which event your beneficiary will be notified that an additional period of 60 days is required to process the claim. The notice will include the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision.

If the Plan Administrator Denies the Appeal

If your beneficiary's claim for benefits is denied in whole or part by the Plan Administrator, written notice of the decision to deny such application will be promptly furnished to your beneficiary within 60 days after receipt of the claim for benefits, or within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the claim. Notwithstanding the foregoing, if the Plan Administrator's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Plan Administrator's final determination may be made within the period specified in Department of Labor Regulations Section 2560.503-1(i)(ii). Each notice of denial of an application shall be in writing and shall contain the following information:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A statement that your beneficiary is entitled to receive upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claimant has exhausted all claims and appeals to the Claims Administrator and Plan Administrator. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date of the covered person's death.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Short-Term Disability Plan

The claim determination and appeal process described below applies to the Short-Term Disability Plan. As used in this section, (i) the term "Plan" refers to the Short-Term Disability Plan, (ii) the term "Claims Administrator" refers to the applicable claims administrator appointed for the Plan, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in the Plan or a rescission of your disability coverage (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission,"

means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) before you request a formal appeal. If you are not satisfied with a benefit determination, you can appeal it.

Consideration of the Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but generally not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding Your Claim

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a

statement that such explanation will be provided free of charge upon request; and

- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written or electronic notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- a description of the Plan's review procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following exhaustion of the claims procedure process;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits, you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 180 days of the receipt of the written adverse benefit determination.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request should also include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by

you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an individual who is neither the person who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such person.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claims Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For claims filed after April 1, 2018, before the Claims Administrator issues and averse benefit determination on appeal, it will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person (or at the direction of the Plan or such other person) making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on appeal based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination on review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Appeal

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Claims Administrator makes an adverse benefit determination on your appeal, it will notify you of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the benefit determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- a statement indicating your right to file a lawsuit upon completion of the appeal process.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the

Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination on your appeal, it will notify you in writing or electronically of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement indicating (A) your right to bring an action under section 502(a) of ERISA upon exhaustion of the claims procedure process, (B) that any such action must be brought no later than three years after the date an initial claim should have been filed under these claims procedures, and (C) the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Appeal to the Plan Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim on review, you or your duly authorized representative may appeal the Claims Administrator's determination by sending a written request to the Plan Administrator within 45 days of your receipt of the Claims Administrator's adverse benefit determination on review.

The Committee, as Plan Administrator, has delegated to the Director, Benefits, the Director, Corporate Insurance and the Senior Vice President and Chief Human Resources Officer, and to the officers or employees of the Company or of its affiliates succeeding to the duties and responsibilities of such persons, the authority to decide appeals of denied claims on behalf of the Plan Administrator. Such appeals shall be decided by the Director, Benefits and the Director, Corporate Insurance, or by the officers or employees of the Company or of its affiliates succeeding to the duties and responsibilities of such persons. In the event such persons do not agree on the decision with respect to an appeal, the Senior Vice President and Chief Human Resources Officer, or the officer or employee of the Company or of its affiliates succeeding to the duties and responsibilities

of such person, shall decide the appeal. References in this section to the "Plan Administrator" shall be deemed to constitute references to those persons to whom the Plan Administrator has delegated authority to decide appeals of denied claims.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written appeal should state why you think your claim should not have been denied. Your appeal should also include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in your appeal to the Claims Administrator. The review will not afford deference to the Claims Administrator's decision.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of any such individual.

The Plan Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For claims filed after April 1, 2018, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Plan Administrator or other person (or at the direction of the Plan or such other person) making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Plan Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.

If the Plan Administrator Makes an Adverse Benefit Determination on Your Appeal

Claims Filed On or Before April 1, 2018

For claims filed on or before April 1, 2018, if the Plan Administrator makes an adverse benefit determination with respect to your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria were relied upon and that a copy will be provided free of charge upon request.

Claims Filed After April 1, 2018

For claims filed after April 1, 2018, if the Plan Administrator makes an adverse benefit determination on your claim on review, it will notify you in writing or electronically of the following, in a manner to be understood by you:

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement indicating (A) your right to bring an action under section 502(a) of ERISA upon exhaustion of the claims procedure process, (B) that any such action must be brought no later than three years after the date an initial claim should have been filed under these claims procedures, and (C) the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Physical Examinations

The Company has the right, at its own expense, to have any person for whom a claim is pending examined as often as is reasonably necessary.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the time a claim should have been filed.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Long-Term Disability Plan

The claim determination and appeal process described below applies to the Long-Term Disability Plan. As used in this section, claims made under the Long-Term Disability Plan are referred to as "disability claims." The term "Plan" as used in this section refers to the Long-Term Disability Plan, and the term "Claims Administrator" refers to The Prudential Insurance Company of America. As used in this section, "adverse benefit determination" or "adverse determination" shall mean any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan, or (ii) any rescission of disability coverage with respect to a claimant (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 after the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For Disability Claims Filed On or Before April 1, 2018

For disability claims filed on or before April 1, 2018, if your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from the Claims Administrator of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the denial,

- references to the specific Plan provisions on which the benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process,

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

For Disability Claims Filed After April 1, 2018

For disability claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your claim, it shall provide you with a written notice of the adverse benefit determination setting forth

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following completion of all required appeals;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

First Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim for benefits, you or your representative may appeal the determination in writing to

the Claims Administrator within 180 days of your receipt of written notice of the adverse determination. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your written request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, without regard to whether such information was submitted or considered in the initial adverse benefit determination, and utilizing individuals who were not involved, and who are not subordinates of the individuals involved, in that determination. This review will not afford any deference to the initial adverse benefit determination.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 45 days after the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, it shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, it shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For Disability Claims Filed On or Before April 1, 2018

For disability claims filed on or before April 1, 2018, if the claim on appeal is denied in whole or in part, you will receive a written notification from the Claims Administrator of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- the specific reason(s) for the adverse determination,
- references to the specific Plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures; and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free

of charge, or you will be informed that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

For Disability Claims Filed After April 1, 2018

For disability claims filed after April 1, 2018, if the Claims Administrator makes an adverse benefit determination with respect to your disability claim on review, it will provide you with written notice. The notice shall set forth, in a manner calculated to be understood by you,

- the specific reason or reasons for the adverse determination;
- a reference to the specific Plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures;
- a statement indicating
  - your right to bring an action under section 502(a) of ERISA upon completion of all required appeals,
  - that any such action must be brought no later than three years after the date of the adverse benefit determination with respect to your first appeal to the Claims Administrator, and
  - the calendar date upon which such limitations period expires;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Second Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination with respect to your claim on review, you or your representative may make a second, voluntary appeal of the adverse determination in writing to the Claims Administrator within 180 days of your receipt of the written notice of adverse benefit determination. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the

right to obtain copies of, all documents, records and information relevant to your claim free of charge.

The Claims Administrator shall make a determination on your second claim appeal within a reasonable period of time, but not later than 45 days after the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Claims Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review, it shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Claims Administrator or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

For disability claims filed after April 1, 2018, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, it shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under the Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the Claims Administrator makes an adverse benefit determination with respect to your second-level, voluntary appeal, you will receive a written notification from the Claims Administrator of the adverse determination. The notice will be written in a manner calculated to be understood by you and shall include the same type of information that was included in the letter notifying you of the adverse benefit determination on your first-level appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud, (ii) any error the Claims Administrator makes in processing a claim, and (iii) your receipt of deductible sources of income. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims

procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, unless otherwise provided under federal law, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date of the adverse benefit determination with respect to your first appeal to the Claims Administrator.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to

decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary, and
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the

subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan. Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." For example, as of the date of this Handbook, the personnel policy of the Company and each Participating Employer is to terminate your employment if the claims fiduciary of the Company's long-term disability plan determines you no longer qualify for benefits under the long-term disability plan. The leaves referred to above are:

Sick Leave – Coverage under the Medical, Dental, Vision and FSA Plans for you and your eligible dependents continues if you are on sick leave and your Employer under its personnel policies continues to treat you as an employee. Your contributions for this coverage will continue to be deducted from your check.

Long Term Disability Leave ("LTD") – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents, as well as coverage under the Health Care FSA, continues if you are on LTD leave and your Employer under its personnel policies continues to treat you as an employee. You must continue to make your required contribution. You may also receive

an Employer contribution to your Health Savings Account if you are enrolled in an HDPPO coverage option and are eligible to contribute to a Health Savings Account.

You **cannot** continue to participate in the Dependent Care FSA while you are receiving Long-Term Disability Plan benefits. You may, however, use the existing balance in your account to pay for any eligible expense you incur before you commence your LTD leave.

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage

under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes

a loss of coverage under the Health Care FSA, you may continue your current contributions to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to provide any group health plan or coverage to any employee.
- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at dol.gov/ebsa (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the

Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your

direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce

future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure

that only persons involved in Plan administration have access to Protected Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the

Benefit Plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

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

5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Medical Coverage for Retirees

You may be eligible for medical benefits as a retired employee if you meet certain eligibility requirements. For further information about your eligibility for medical benefits as a retired employee or to notify the Company or your Employer of your retirement, contact the Benefits Source at **1-888-640-3320**.

Unless you are rehired as a Safety Plan Rehire or as a union employee of Northern Indiana Public Service Company LLC , if you retire or otherwise terminate employment and are later rehired by the Company, a Participating Employer, or any of their affiliates, you will not be eligible for retiree medical or retiree life insurance benefits, including after your subsequent retirement or other termination of employment.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible†	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

†Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	**Out-of-Network**
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

	PPO	
	In-Network (or out of area)	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$3,000	$6,000	$5,000	$10,000

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

TYPE OF SERVICE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

TYPE OF SERVICE	HDPPO 1 In-Network Plan Pays	HDPPO 1 Out-of-Network Plan Pays	HDPPO 2 In-Network Plan Pays	HDPPO 2 Out-of-Network Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers,

distributors, and/or similar vendors, which may be related to certain prescription drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and

  - Prescribed medications (Outpatient prescription drug services are covered under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).
- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;

  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam and one hearing aid per ear during a two calendar-year period; and
- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational

therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;
- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance,

when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

  See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age,

gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

  See the following website for additional information:
  https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;

- Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);
- Screening for gestational diabetes;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

  - Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

  - Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
  - Inpatient covered hospital services related to the transplant procedure.
  - Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay*
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay *	**Plan Pays**	**You Pay ***	**Plan Pays**	**You Pay ***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

Please Note: Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Preventive Dental

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Opt-Out Credit

Please see the subsection of the **Benefits Program Overview** entitled *"Opt-Out Credit"* for information concerning whether you may be entitled to an opt-out credit under the Plan.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum); 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process –* Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network

schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA FEATURES	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. *A non-exhaustive list of eligible expenses can be found later in this section.*
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A non-exhaustive list of eligible expenses can be found later in this section.*

FSA FEATURES	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 40.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;

- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;

- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website **mysourceforhr.com**.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 42.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.
- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax*

purposes. Please consult your tax advisor for more information.

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out

of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Travel Accident Plan

Your Travel Accident Benefit

This is the SPD (the "Travel Accident SPD") for the NiSource Travel Accident Plan, also referred to as the Travel Accident Plan. In this Travel Accident SPD, the Travel Accident Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the Plan to eligible employees to cover accidental death sustained during the course of a trip made on behalf of a Participating Employer.

For purposes of the Plan, a trip "made on behalf of a Participating Employer" means travel and sojourn authorized by, or at the direction of, a Participating Employer for purposes of furthering the business of the Participating Employer. A trip will be considered as commencing when you leave your residence or place of employment, whichever you leave last, for the purpose of going on such trip, and the trip will continue until you return to your residence or place of regular employment, whichever you return to first.

All eligible employees are covered for $50,000 in death benefits.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process – Travel Accident Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 44.

Eligibility

For information regarding eligibility under the Travel Accident Plan, please see the *"Eligibility under the Travel Accident Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Travel Accident Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Travel Accident Plan"*.

Contributions

The Employer pays the full cost of the Travel Accident Plan. There are no employee contributions.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Travel Accident Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Travel Accident Plan"*.

Beneficiary Designation

Your beneficiary will be the beneficiary or beneficiaries that you named under the NiSource Life Insurance Plan. (Please see the "*Life and AD&D Plan"* section of this Handbook for further details on beneficiary designation.)

If you fail to designate a beneficiary before your death, or if your beneficiary dies before you die, benefits are paid according to the default rules established under the NiSource Life Insurance Plan.

You and your beneficiary need to keep the Company advised of the addresses at which each of you can be located. If the Company cannot locate you or your beneficiary when benefits become payable, notification will be mailed to the most recent address on file. The Claims Administrator is not required to search for, or locate, you or your beneficiary. Please be sure to notify the Benefits Source should you or your beneficiary change addresses.

If a beneficiary becomes entitled to a payment under the Plan and it cannot be

made because (1) the current address is incorrect, (2) the beneficiary does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

To designate or change your beneficiary(ies) go online via the Benefits Source website at mysourceforhr.com or call the Benefits Source toll-free number at **1-888-640-3320** to speak with a customer service associate.

Travel Accident Benefit Exclusions

The Plan does not cover any accidental death incurred due to:

- Commuting to and from work, and any travel during lunches, breaks and vacations;
- Suicide or any attempted suicide while sane or self-destruction or an attempted suicide while insane;
- Declared or undeclared war or any act of either within the United States, the District of Columbia or Canada;
- Service in the armed forces of any country; provided, however, orders to active military service for two months or less will not constitute service in the armed forces; or
- Sickness or disease, except infections that occur through an accidental cut or wound.

Filing a Claim

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim under the claims procedures described below.

In the event of death or covered loss, your beneficiary must contact the NiSource Benefits Department at 801 E. 86th Avenue, Merrillville, Indiana 46410 within 31 days or as soon as reasonably possible in order to receive benefits.

Any claims submitted after 18 months from the date of death or covered loss may not be considered for payment.

The Plan pays benefits based on the coverage that was in effect on the date of your death. The benefit is paid in the form of a lump-sum payment.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Travel Accident Plan."*

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Travel Accident Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Travel Accident
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Company and Participating Employers
Contribution Source:	Employer
Plan Sponsor:	NiSource Inc. 801 E. 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 E. 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Claims are administered by the Claims Administrator listed below Benefits will be paid under the Plan only if the applicable Plan Administrator or its delegate (e.g. the Claims Administrator) determines that the claimant is entitled to them.
Claims Administrator:	NiSource Benefits Department 801 E. 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

Service of legal process may be made upon the Plan Administrator

Short-Term Disability Plan

Your Short-Term Disability Plan

This is the SPD for the NiSource Short-Term Disability Plan (the "Plan" or "Short-Term Disability Plan").

NiSource Inc. (the "Company") and the Participating Employers provide eligible employees with short-term disability ("STD") and sick leave coverage under the Plan at no cost to the employee. Your Employer provides you with limited income continuation should you become Disabled and unable to work because of a short-term Sickness or Injury (as defined below).

How Your Paid Sick Leave Works

Generally, if you are an eligible employee, you are granted paid sick leave on the first day of the month coincident with or next following the completion of six continuous months of active full-time employment with an Employer. All covered absences due to Sickness or Injury will be deducted from your sick leave balance and will be paid in accordance with the schedule set forth in the *"Highlights of Your Short-Term Disability Plan Coverage"* section of this SPD.

Your Plan benefit is determined by your credited service years. Please see the *"Highlights of Your Disability Plan Coverage"* section for further details.

If you use all of your paid sick leave time and you are still unable to return to work, you will be on an unpaid leave of absence. You may continue in this unpaid status until:

- You are eligible to receive Long Term Disability Plan Benefits;
- You return to work;
- You terminate employment; or
- You retire.

If you are still on sick leave at the end of December and you remain unable to work into the next calendar year, you continue to use remaining sick leave from the previous year. Subject to the terms, conditions and limitations described below in "*Recurring or Separate Periods of Disability," y*ou will not receive additional hours of paid leave until you return to work for one full day in the new year. This means that you will not be granted additional hours of paid sick leave for the new year while you are absent due to Sickness or Injury.

For purposes of the Plan, "Sickness" means a disease, disorder or condition of the body or mind, including pregnancy, abortion, miscarriage or childbirth, that requires treatment by a Physician (as defined below), but does not include an Injury. Disability resulting from a Sickness must begin while you are covered under the Plan.

For purposes of the Plan, "Injury" means a bodily injury that is the direct result of an accident, that is not related to any cause other than the accident, the results in immediate disability, and that requires treatment by a Physician. Disability resulting from an Injury must begin while you are covered under the Plan.

Disability Under the Short-Term Disability Plan

If you are Disabled (as described below), you will be eligible for Plan benefits for up to maximum period of 26 weeks, at which time you may be eligible to receive Long-Term Disability Plan benefits. (See the *"Long-Term Disability Plan"* section of this Health and Welfare Benefits Handbook for details.) For Plan benefit purposes, as explained in greater detail below, you are considered "Disabled" or to have incurred a "Disability" if your Sickness (including pregnancy) or Injury prevents you from performing the essential functions of your own occupation.

There are different types of Disabilities for which you may qualify. They are defined as follows:

Total Disability

You are considered Totally Disabled if you are mentally or physically unable, due to Sickness or Injury, to perform the essential functions of your own occupation or any job requiring similar education or training that an Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case and you are absent from work for

more than four consecutive work days, you must be under the regular care of a Physician* and furnish proof of your Disability to the Claims Administrator. As used in the Plan, "essential functions" means functions that (i) are normally required for performance of your own occupation or any job requiring similar education or training that an Employer offers you and for which you are reasonably qualified by reason of your education, training, or experience, and (ii) cannot be reasonably omitted or modified.

Partial Disability

You are considered Partially Disabled if you are mentally or physically unable, due to Sickness or Injury, to perform, on a full time basis, the essential functions of your own occupation or any job requiring similar education or training that an Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case and you are absent from work for more than four consecutive days, you must be under the regular care of a Physician* and furnish proof of your Disability to the Claims Administrator.

Please Note: If you are Partially Disabled, you may be assigned temporary modified work. The temporary modified work assignment must be approved by your personal physician, the Company physician (where appropriate) and your supervisor.

Please Note: If you require a professional license or certification for your occupation and you lose that license or certification, the loss (in and of itself) does not constitute a Disability under the Plan.

**As used in this SPD, "Physician" means a person who is performing tasks that are within the limits of his or her medical license and is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or who has a doctoral degree in psychology (Ph.D or Psy.D) whose primary practice is treating patients; or who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction. It cannot be any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you send to us.*

Recurring or Separate Periods of Disability

If you are collecting Plan benefits due to a Disability, you temporarily recover, you return to work for your Employer for 180 consecutive calendar days or less, and you then again become Disabled due to the same or a related Sickness or Injury, your subsequent Disability is considered a recurring Disability. This means that you will be entitled to benefits for the recurring Disability for the maximum benefit period, less the benefits you have already received for that Disability.

If you are collecting Plan benefits, you temporarily recover, you return to work for your Employer for 181 or more consecutive calendar days, and you then again become Disabled due to the same Sickness or Injury, your Disability is considered a separate Disability. This means that you will be entitled to benefits for the separate Disability for your maximum benefit period. This amount will not be reduced by the benefits you already received for that Disability.*

*However, in no event will you entitled to benefits under the Plan during a calendar year in excess of the benefits applicable to you as described in the schedule set forth in the *"Highlights of Your Short-Term Disability Plan Coverage"* section of this SPD.

Eligibility

For information regarding eligibility under the Short-Term Disability Plan, please see the *"Eligibility under the Short-Term Disability Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Short-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Short-Term Disability Plan"*.

Contributions

Your Employer pays the full cost of the Plan. There are no employee contributions.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Short-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Short-Term Disability Plan"*.

Highlights of Your Short-Term Disability Plan Coverage

Your Plan benefit is determined according to your length of service and can extend up to 26 weeks during a calendar year, based on the following schedule:

CREDITED YEARS OF SERVICE	You Receive 100% of Your Base Salary for the First…	Then You Receive 60% of Your Base Salary for the Remaining…
More Than Six Months of Service But Less Than One Year of Service	1 Week	0 Weeks
From One Year of Service to Nine Years of Service	8 Weeks	18 Weeks
From Ten Years of Service to Nineteen Years of Service	16 Weeks	10 Weeks
Twenty or More Years of Service	26 Weeks	0 Weeks

For purpose of determining the number of weeks of benefits to which you are entitled, Base Salary and Years of Service shall be determined as of the January 1st immediately prior to the date of Total Disability, except that

(i) if you have more than six months but less than one Year of Service, Base Salary and Years of Service shall be determined as of the date of Total Disability, and

(ii) (ii) if you are a rehired employee who is entitled to credit for prior Years of Service, in the year you are rehired, Base Salary shall be determined as of the date of Total Disability and Years of Service shall be determined as of the date of your rehire according to rules described below with respect to crediting of service for rehires.

Your Plan benefits may end prior to the periods set forth in this schedule for reasons described in the "When Benefits End" section below.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the time a claim should have been filed. For more information, see the *"Claims Determination and Appeal Proc*ess – STD Plan*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 51.

Determining Years of Service

Generally

Upon your first year anniversary, you are credited with one Year of Service. On the December 31 following your first anniversary and each subsequent December 31 thereafter, you are credited with an additional Year of Service.

Crediting of Service for Rehires

If you terminated employment with, or retired from, an Employer and are rehired, you will receive credit under the Plan for Years of Service as follows:

Date of Rehire	Credit for Years of Service
Less than one year after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, including time of break
At least one year, but less than five years, after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, but excluding time during break in service.
At least five years after termination of employment or retirement from employment	No service credit. Participant begins with zero Years of Service upon rehire.

Crediting of Service for Rehires Who Previously Worked for Columbia Pipeline Group

If (i) you were an active employee of Columbia Pipeline Group, Inc. or its affiliates as of July 1, 2015, (ii) you terminated employment, or retired from employment, with Columbia Pipeline Group, Inc. or its affiliates on or after July 1, 2015, and (iii) you were thereafter rehired by an Employer, you will receive credit under the Plan for Years of Service as follows:

Date of Rehire	Credit for Years of Service
On or after July 1, 2015 and before July 1, 2016	All service with an Employer from the date of original hire prior to July 1, 2015 to and including the date of rehire by an Employer on or after July 1, 2015.
On or after July 1, 2016 and before July 1, 2020	All service with an Employer from the date of original hire prior to July 1, 2015, to and including June 30, 2015
On or after July 1, 2020	No service credit. Participant begins with zero Years of Service upon rehire.

Determination of Benefits Generally

Subject to the "How Your Paid Sick Leave Works" and the "Recurring or Separate Periods of Disability" sections of this SPD and upon your first year anniversary, you are entitled to receive benefits for the full benefit period of 26 weeks (1040 hours) for each calendar year.

To determine your Plan benefit, the Plan takes a percentage of your Base Salary*. This is called your "gross Plan benefit" The Plan then deducts any "other sources of disability income" from this amount to determine your "net Plan benefit."

Special provisions apply and are described below if you are Partially Disabled and are able to perform a temporary modified work assignment.

*"Base salary" means your basic earnings plus any before tax deposits deferred under a qualified retirement plan of an Employer. If you receive sales commissions, your Base Salary will be your average hourly wage based on the 12 consecutive calendar months immediately preceding the last day you were actively at work.

Your Base Salary does not include:

- Overtime;
- Shift differentials;
- Bonuses; or
- Any other form of special compensation.

Other Sources of Disability Income

You may be eligible for income from other sources due to your Disability. If this is the case, your benefits under the Plan will be fully offset by such other sources of Disability income.

Other sources of Disability income for which you are eligible, or that have been paid to you or to a third party on your behalf may include, but are not limited to, the amount of any benefit for loss of income for the same Disability from:

- The United States Social Security Act, the Railroad Retirement Act, the Jones Act, or similar plan or act
- Any temporary or permanent disability benefits under a Workers' Compensation law (does not include permanent impairment award), occupational disease law, or similar law
- The Veteran's Administration or any other foreign or domestic governmental agency
- Any governmental law or program that provides disability or unemployment benefits as a result of your employment with an Employer, including any state disability program;
- Disability benefits from any compulsory "no-fault" automobile insurance.

If you receive a benefit from another source of income in the form of a single lump sum, the amount of offset to the weekly benefit amount will be determined by prorating the lump sum over a period of 26 weeks.

State Disability Programs

If you work in a state that requires a state-defined disability plan, you are also covered under the provisions of the laws and regulations of that state plan. Your gross Plan benefit is reduced by the amount you are eligible to receive under any state disability program.

Applying for Other Sources of Disability Benefits

If you are eligible to receive disability benefits from other sources, you should apply as soon as possible. You should notify the Claims Administrator that you are eligible to receive other disability income as soon as possible.

When Benefits End

Your benefit payments will end as set forth in the schedule above, or sooner if any of the following events occur:

- You fail to submit evidence of your Disability or such other documents (if any) that the Plan deems necessary to administer the Plan, in accordance with Plan procedures;
- You do not comply with the Plan's request for evidence of your continuing Disability,

an independent medical examination or other examinations or tests;

- You fail or refuse to perform any temporary modified work assignment, in the case of a Partial Disability;
- You fail to participate in or comply with all requirements of the Disability Management Program;
- You are engaged in any other occupation or earn any self-employment income in excess of a de minimis amount;
- You are not under the regular care of a physician as required by your condition or you are not following the physician's treatment plan;
- You participate in and are convicted of a felony offense. In such case, your Disability will be determined to have ceased as of the date that you first participated in the felony offense;
- You commit or partake in any actions of fraud against the Plan or an Employer;
- You are no longer considered by the Plan to be Disabled;
- Your 26-week benefit period ends;
- You become eligible for LTD Plan benefits;
- You have been terminated or have voluntarily terminated employment with an Employer (other than transfer to another Employer);
- You are no longer eligible for coverage under the Plan; or,
- You die.

Plan Benefit Exclusions

The Plan does not pay benefits under certain circumstances. These circumstances include, but may not be limited to, the following:

- Failure to participate in or provide the Disability Management Program with all the required documentation regarding your Disability.
- Sickness or Injury that occurs while:
  - You are on a leave of absence;
  - You are furloughed from work;
  - You are suspended from work; or
  - You are considered an inactive employee.
- Disability that is caused or contributed to by an intentionally self-inflicted injury.
- If you are absent from work for more than four consecutive work days and the disability is not being treated by a Physician.
- Disability caused or contributed to by war or an act of war (declared or not).
- Disability caused by your commission of or attempt to commit a crime for which you have been convicted, or to which a contributing cause was your involvement in an illegal occupation.

Claiming Benefits

If you are unable to work because of Sickness or Injury, you must adhere to the following procedures to qualify for Plan benefits:

- Call your supervisor before your normal work day begins. If that is not possible, be sure to contact your supervisor as soon as you can. If you cannot call in, please be sure that someone calls in on your behalf. *Your Employer may require that you provide a Physician's statement confirming your Sickness or Injury before your absence is actually approved.*
- If you are, or know you will be, absent from work for more than four consecutive work days, call the Benefits Source at 1-888-640-3320 or the Claims Reporting Hotline at 1-877-ENERGY4, Option #3, then Option #1, to report your Sickness or Injury to the Plan's Disability Management Program.

Disability Management Program

You must participate in the Disability Management Program to qualify for Plan benefits. The Disability Management Program certifies that you qualify for Plan benefits beyond the fourth day of absence. You will

be assigned a "Claims Administrator" who will:

- Guide you through the disability benefits that may apply to your situation;
- Certify whether your disability qualifies for STD pay; and
- Help develop a reasonable return-to-work plan with you, your physician, and your supervisor.

You will be expected to participate fully in the Disability Management Program. You must:

- Supply the authorization and documentation as described in the following section;
- Maintain contact with your Claims Administrator;
- Follow the medical treatment plan that is agreed to by your Claims Administrator and your physician; and
- Return to work at the time that is agreed to by you, your Claims Administrator, your physician, and your supervisor.

Authorization and Documentation You Will Need to Supply

Upon request from the Claims Administrator, you may need to provide certain information. Failure to provide this information may deny, suspend or terminate your Plan benefits. The information includes, but is not limited to the following:

- Signed authorization form for the Claims Administrator to obtain all reasonably necessary medical, financial, or other non-medical information that supports your Disability claim.
- Proof that you have applied for other sources of disability income (i.e., Workers' Compensation, State Disability Benefits, or Social Security Disability Benefits, when applicable).
- Notification of when you receive or are awarded a benefit from another source of disability income, including the:
  - Type of income benefit;
  - Amount you are receiving;
  - Period for which the benefit applies; and
  - Duration for which the benefit is being paid (if you are receiving installment payments).

Also, your Employer may require a "doctor's release" to return to work.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Short-Term Disability Plan."*

Other Information

If Your Disability Reaches Five Months in Duration

You should apply for Social Security disability benefits by the end of the fourth month from the day your Disability began. (The Claims Administrator can help you with the filing process). In addition, if you are eligible to receive disability benefits from another source, you should apply as soon as possible.

Temporary Modified Work Assignment

If you qualify for a Partial Disability and you are working on a temporary modified work assignment, you will receive your Base Salary for the hours you work and Plan benefits (based on the Plan's provisions) for the hours you are not working.

If, in the Claims Administrator's opinion, you could perform a temporary modified work assignment (given your condition) and you refuse the assignment, the Plan benefit for which you would be otherwise eligible ends.

Family and Medical Leave Act (FMLA)

While collecting Plan benefits, you may also be eligible for leave under the Family and

Medical Leave Act of 1993 (FMLA). If you are eligible for and approved for a FMLA leave for your own serious health condition, your FMLA leave will run concurrently with Plan coverage for up to 12 weeks. Please refer to your Employer's FMLA Policy.

Continuation of Other Coverages

Certain coverages provided to you under the Program may continue while you are receiving Plan benefits or if you have an appeal pending in accordance with the provisions of the Plan. Any contributions that you are required to make toward the cost of these coverages (as well as your contributions to a retirement plan sponsored by an Employer) will be deducted from your Plan benefits. If your Plan benefits are insufficient to cover all of your benefit deductions, the Benefits Source will work with you to set up a direct billing arrangement. If you have any questions regarding these coverages, call the Benefits Source at **1-888-640-3320.**

Medical, Dental, Vision, and FSA Plans

For continuation of coverage under the Medical, Dental, Vision, and FSA Plans , see the General-Sick Leave subsection of the section of the **Benefits Program Overview** entitled "Continuation of Coverage under the Medical, Dental, Vision and FSA Plans."

Life and AD&D

Life and AD&D coverage for you and your eligible dependents continues.

LTD Disability

LTD coverage continues.

(Please Note: If your Disability continues and you meet the eligibility requirements, you may qualify for Long-Term Disability Plan benefits. See the *"Long-Term Disability Plan"* section of this Handbook for details.)

Retirement Plans

You continue to earn service under any retirement plan sponsored by an Employer for which you are otherwise eligible while collecting Plan benefits. In addition, you can continue to make elective deferrals (and the Company will continue to make matching contributions, as applicable) to any retirement plan allowing elective deferrals for which you are otherwise eligible while you are collecting Plan benefits. You may, however, stop your contribution to such retirement plan(s) at any time. Please see the applicable retirement plan(s) for further information.

Other Programs

If benefits under the Adoption Assistance Plan would otherwise be available to you, these benefits will not be available to you while you are collecting Plan benefits.

Contact Information

If you need answers to specific coverage related questions, contact the Benefits Source by going to their website or using their automated telephone system. Both the website and the automated telephone system can connect you with the Claims Administrator (if necessary).

Coverage Option	Contact
Short-Term Disability Plan	ESIS mysourceforhr.com (link to ESIS.com) 1-888-640-3320 (Benefits Source) You can connect with the Claims Administrator by phone via the Benefits Source automated telephone system.

General Plan Information

Program Name	NiSource Welfare Benefits Program
Plan Name:	NiSource Short-Term Disability Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Short-Term Disability
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions, and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-5539
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under the Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., the Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	ESIS Two Riverway Suite 1100 Houston, Texas 77056
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Long-Term Disability Plan

Basic LTD Coverage

Supplemental LTD Coverage

Your Long-Term Disability Options

NiSource Inc. (the "Company") offers the NiSource Long-Term Disability Plan (the "Plan") to eligible employees with the following coverage options:

- Basic LTD Coverage Option; and
- Supplemental LTD Coverage Option.

Benefits are provided under a group insurance contract (the "Group Contract") and a group insurance certificate (the "Group Insurance Certificate") issued by The Prudential Insurance Company of America ("Prudential"), who is the Claims Administrator and is wholly responsible for the payment of benefits.

You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description. *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at 1-888-640-3320.*

The Plan provides financial protection for you by paying a portion of your income while you have a long period of disability. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits begin after the elimination period is completed. The elimination period is the period of continuous disability that must be satisfied before you are eligible to receive benefits and is the longest of (i) 180 days; (ii) the length of time for which you receive loss of time benefits, salary continuation or accumulated sick leave; and (iii) the date that you are absent from work for 1040 hours due to your disability.

If you are determined to be disabled, the Basic LTD Coverage Option provides monthly benefits of the lesser of (i) 50% of your monthly earnings, not reduced by any deductible sources of income, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $8,333.00.

If you are determined to be disabled, the Supplemental LTD Coverage Option provides monthly benefits of the lesser of (i) 60% of your monthly earnings, not reduced by any deductible sources of income, (ii) 70% of your monthly earnings, less any deductible sources of income, or (iii) $10,000.00. You pay a portion of the cost of the Supplemental LTD Coverage Option.

Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under the Plan. See *"Taxability of Monthly Benefits"* below for information regarding the taxability of monthly benefits you receive under the Plan. Refer to the Group Insurance Certificate for further details.

See "*Highlights of the Long-Term Disability Plan Coverage*" below for examples illustrating the payment of monthly benefits.

Eligibility

For information regarding eligibility under the Long-Term Disability Plan, please see the *"Eligibility under the Long-Term Disability Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Long-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Long-Term Disability Plan"*.

Contributions

The Basic LTD Coverage Option is provided at no cost to you. If you elect the Supplemental LTD Coverage Option, you and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. *If you have questions regarding the amount of your required contributions, please contact the Benefits Source at* ***1-888-640-3320****.*

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Long-Term Disability Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends –Long-Term Disability Plan"*.

Highlights of the Long-Term Disability Plan Coverage

The information below describes how the Plan pays benefits if a participant becomes disabled and is unable to work and when a participant becomes disabled, but continues working. See *"Taxability of Monthly Benefits"* below for information regarding the taxability of monthly benefits you receive under the Plan.

If you are Disabled and Not Working

If you have the Basic LTD Coverage Option, your Monthly Payment is the lesser of:

- 50% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $8,333.00 per month.

If you have elected the Supplemental LTD Coverage Option, your monthly payment is the lesser of:

- 60% of Monthly Earnings;
- 70% of Monthly Earnings less any deductible sources of income; or
- $10,000.00 per month

If You Are Disabled and Working

If your monthly disability earnings ("Disability Earnings") are less than 20% of your indexed monthly earnings ("Indexed Monthly Earnings"), your LTD benefit is the same as it would be if you were not working.

If your Disability Earnings are greater than 80% of your Indexed Monthly Earnings, no benefit is payable to you. If benefits have already commenced, Prudential will stop sending you payments and your claim will end.

If you are disabled and your monthly Disability earnings are at least 20%, but not more than 80%, of your Indexed Monthly Earnings, due to the same sickness or injury, Prudential will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as Disability Earnings plus the gross disability payment does not exceed 100% of Indexed Monthly Earnings.

1. Add your monthly Disability Earnings to your gross disability payment.
2. Compare the answer in item 1 to your Indexed Monthly Earnings.

If the answer from item 1 is less than or equal to 100% of your Indexed Monthly Earnings, Prudential will not further reduce your monthly payment.

If the answer from item 1 is more than 100% of your Indexed Monthly Earnings, Prudential will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your Disability.

1. Subtract your Disability Earnings from your Indexed Monthly Earnings.
2. Divide the answer in item 1 by your Indexed Monthly Earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

The minimum monthly payment is the greater of (a) 10% of the gross disability payment otherwise payable, and (b) $100.

If your Disability Earnings are expected to fluctuate widely from month to month, Prudential may average your Disability Earnings over the most recent 3 months to determine if your claim should continue subject to all other terms and conditions of the Plan. If Prudential averages your

Disability Earnings, it will terminate your claim if the average of your Disability Earnings form the last 3 months exceeds 80% of Indexed Monthly Earnings. Prudential will not pay you for any month during which Disability Earnings exceed the foregoing amounts.

Definition of "Disability"

You are "disabled" when Prudential determines that:

- you are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury;
- you have a 20% or more loss in your monthly earnings due to that sickness or injury; and
- you are under the regular care of a doctor.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury,

- you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and
- you are under the regular care of a doctor.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received by Prudential within 30 days of its request.

Prudential may require you to be examined by doctors, other medical practitioners or vocational experts of its choice. It will pay for these examinations. Prudential can require examinations as often as it is reasonable to do so. It may also require you to be interviewed by an authorized Prudential Representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Additional Definitions

Active employment means you are classified as working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least 40 hours per week. Your worksite must be: your Employer's usual place of business; an alternate worksite at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or a location to which your job requires you to travel. Normal vacation is considered active employment. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Deductible sources of income means income from deductible sources listed in the Group Insurance Certificate that you receive or are entitled to receive while you are disabled. This income may be subtracted from your gross disability payment. Examples of deductible sources of income include but are not limited to (a) amounts you receive or are entitled to receive as (i) loss of time benefits under a workers' compensation law, an occupational disease law or any other act or law with similar intent; or (ii) loss of time disability income payments under any state compulsory benefit act or law, any insurance, health or welfare plan or other group insurance plan where the Employer, directly or indirectly, has paid all or part of the cost or made payroll deductions, or any governmental retirement system as a result of your job with your Employer; (b) the gross amount you receive or are entitled to receive as loss of time disability payments because of your disability under the United States Social Security Act or any similar plan or act; (c) the gross amount you receive as retirement payments under the United States Social Security Act or any similar plan or act; (d) the amount your receive as "wages" under the maritime doctrine of maintenance, wages and cure; and (e) the amount you receive, due to your disability, from a third party (after subtracting attorneys' fees and a pro-rata share of reasonable fees and costs) by judgement, settlement or otherwise. Refer to

the Group Insurance Certificate for a complete list of these sources.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations: (i) during the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation, that is reasonably available; and (ii) beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience. Salary continuance paid to supplement your disability earnings will not be included as disability earnings because it is not payment for work performed.

Gainful occupation means an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 50% of your monthly earnings, if you are not working. However, if you enrolled in the Supplemental LTD Coverage Option, it means an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work that exceeds 80% of your indexed monthly earnings, if you are working, or 60% of your monthly earnings, if you are not working

Gross disability payment means the benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1, provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Injury means a bodily injury that is the direct result of an accident, that is not related to any other cause, and that results in immediate disability. Disability must begin while you are covered under the Plan.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, Prudential will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Monthly earnings means your total annual income before taxes divided by 12. It is determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer. Commissions will be averaged for the lesser of: (a) the 24 full calendar month period of your employment with your Participating Employer just prior to the date disability begins; or (b) the period of actual employment with your Employer.

Regular occupation means the occupation you are routinely performing when your disability occurs. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the Plan.

Taxability of Monthly Benefits

Because your Employer pays the entire cost of your Basic LTD Coverage and does not include this cost in your gross-income, and because you pay for any Supplemental LTD Coverage

on a pre-tax basis, any monthly benefits you receive under the Plan will be taxable to you pursuant to the Code and guidance issued thereunder.

Maximum Period of Payments

The longest period of time the Plan will make payments to you for any one period of disability (your "maximum period of payment") is as follows:

Your Age on Date Disability Begins	Your Maximum Period of Payment
Less than 60	To age 65
Age 60 and over	60 months

Prudential will stop sending you payments while you are incarcerated as a result of a conviction.

In addition, Prudential will stop sending you payments and your claim will end on the earliest of the following:

- During the first 24 months of payments, when you are able to work in your regular occupation on a "part-time basis" but you choose not to; after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to. "Part-time basis" means the ability to work and earn 20% or more of your indexed monthly earnings.
- The end of the maximum period of payment.
- The date you are no longer disabled under the terms of the Plan.
- The date you fail to submit proof of continuing disability satisfactory to Prudential.
- The date your disability earnings exceed the amount allowable under the Plan.
- The date you retire.
- The date you die.
- The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by your doctor.

Notwithstanding the above, disabilities due to a sickness or injury which, as determined by Prudential, are primarily based on self-reported symptoms have a limited pay period during your lifetime. "Self-reported symptoms" means the manifestations of your condition, which you tell your doctor, that are not verifiable using tests, procedures and clinical examinations standardly accepted in the practice of medicine. Examples include, without limitation, headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Also, disabilities which, as determined by Prudential, are due in whole or part to mental illness also have a limited pay period during your lifetime. "Mental illness" means a psychiatric or psychological condition regardless of cause and includes, without limitation, schizophrenia, depression, manic depressive, or bipolar illness, anxiety, somatization, substance related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

The limited pay period for self-reported symptoms and mental illness combined is 24 months during your lifetime. There are exceptions to the limited pay period rules. Refer to the Group Insurance Certificate for a detailed explanation of these exceptions.

Recurrent Disabilities

If you have a "recurrent disability," as determined by Prudential, your disability will be treated as part of your prior claim and you will not have to complete another elimination period if (a) you were continuously insured under the Plan for the period between your prior claim and your current disability; and (b) your recurrent disability occurs within 180 days of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the Plan as your prior claim.

Any disability which occurs after 180 days from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the Plan provisions.

If you become covered under any other group long term disability plan, you will not be eligible for payments under the Plan.

A "recurrent disability" is a disability that is (a) caused by a worsening in your condition; and (b) due to the same cause(s) as your prior disability for which the Plan made a Long Term Disability payment.

Exclusions from Coverage

The Plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot; or
- commission of a crime for which you have been convicted under state or federal law.

The Plan does not cover a disability which is due to a pre-existing condition.

The plan does not cover a disability due to war, declared or undeclared, or any act of war.

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available; and
- Your disability begins within 12 months of the date your coverage under the Plan becomes effective.

Pre-existing conditions may also affect an increase in your benefits due to an amendment of the Plan or your enrollment in another Plan option. *For further details, refer to the Group Insurance Certificate. You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

Survivor Benefits

When Prudential receives proof that you have died, it will pay your spouse, if living; otherwise, your children under age 25 (your "eligible survivors"), a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. However, Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

Other Services Provided Under the Plan

As part of your coverage under the Plan, Prudential also provides certain benefits in the nature of a Social Security Claimant Assistance Program, a Rehabilitation Program and a program of reimbursing employers for the cost of certain worksite modifications that are identified by your Employer and Prudential as being likely to help you remain at work or return to work. Refer to the Group Insurance Certificate for further details regarding these programs. With respect to the Rehabilitation Program, if at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease paying your monthly benefit.

Filing A Claim

General

Written notice of a claim should be sent to Prudential within 30 days after the date your disability begins. However, you must send Prudential written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than

1 year after the time proof is otherwise required except in the absence of legal capacity. You must notify us immediately when you return to work in any capacity.

*Claim forms can be obtained from Prudential by phone via the Benefits Source at **1-888-640-3320**, or online via the Benefits Source website at mysourceforhr.com. If you do not receive the form from Prudential within 15 days of your request, send Prudential written proof of claim without waiting for the form.*

How to File Claims

You and your Employer must fill out your own section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and send it directly to Prudential.

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a doctor.
- Appropriate documentation of your monthly earnings.
- The date your disability began.
- Appropriate documentation of the disabling disorder.
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation.
- The name and address of any hospital or institution where you received treatment, including all attending doctors.
- The name and address of any doctor you have seen.

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by Prudential.

In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by Prudential. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.

Recovery of Overpayments

Prudential has the right to recover any overpayments due to (i) fraud; (ii) any error Prudential makes in processing a claim, and (iii) your receipt of deductible sources of income.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Long-Term Disability Plan."*

Continuation of Other Coverages

Certain coverages provided to you under the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program continue while you are Disabled and receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee. Any contributions that you are required to make toward the cost of these coverages will be billed to you. For further information regarding the billing arrangement, contact the Benefits Source.

Medical, Prescription Drug, Vision and Dental
Medical, vision and dental coverages for you and your eligible dependents continue while you are receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Life and AD&D
Life and AD&D coverages for you and your eligible dependents continue while you are

receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee and so long as premiums are timely paid.

Health Care Flexible Spending Account

Your Health Care FSA coverage continues while you are receiving Plan benefits, provided your Employer under its personnel policies continues to treat you as an employee.

Dependent Care Flexible Spending Account

You cannot continue to make contributions to the Dependent Care FSA while you are receiving Plan benefits. You may use the existing balance in your account to pay for any eligible expense that you incurred prior to the commencement of your Plan benefits.

HSAs

You may receive an Employer contribution to your HSA if you are enrolled in an HDPPO coverage option and are otherwise eligible to contribute to a Health Savings Account. You may also contribute to your HSA while you are receiving Plan benefits; however your contribution may not be funded out of your Plan benefit payments.

Retirement Plans

While you are receiving Plan benefits, you may continue to earn service under your retirement plans. However, your contributions to the Savings Plan automatically stop. You are eligible to receive the value of your Savings Plan Account due to your disability. Refer to the Savings Plan and your other retirement plans for further information.

Other Programs

The Adoption Assistance and the Tuition Reimbursement Programs are not available to you while you are receiving Plan benefits.

Important Information For Residents Of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and in this summary plan description. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this summary plan description. Prudential has a website that describes these state-specific requirements. You may access the website at prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 93191.

If you are unable to access this website, and if you want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Long-Term Disability Plan (a component of NiSource Welfare Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing disability benefits
Plan Number:	537
Contribution Source:	Basic LTD Coverage: Employer Supplemental LTD Coverage: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102
Claims Administrator: (if you need to submit a claim)	The Prudential Insurance Company of America Prudential Disability Management Services P.O. Box 13480 Philadelphia, Pennsylvania 19176
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. ***In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail***. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

The Prudential Insurance Company of America, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Life and AD&D Plan

Employee Term Life Coverage – Basic and Optional Plans

Dependents Term Life Coverage

Employee AD&D Coverage – Basic and Supplemental Plans

Dependents AD&D Coverage

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Optional Employee Term Life Coverage Option;
- Dependents Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;
- Supplemental Employee AD&D Coverage Option; and
- Dependents AD&D Coverage Option

The Life and AD&D Coverage Options other than the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option are referred to collectively as the "Optional Life and AD&D Coverage Options."

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance") and, if elected, on the persons of your "eligible dependents" ("Dependents Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option. If you elect coverage under any of the Optional Life and AD&D Coverage Options, you will pay for the cost of such coverage. *If you have questions regarding the amount of your required contributions, please contact the Benefits Source at **1-888-640-3320**.*

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and

AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in an amount up to two times (2x) your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. If you are also enrolled in Optional Employee Term Life Coverage, the amount of your Basic Employee Term Life Coverage will be added to your Optional Term Life Coverage before rounding takes place. The maximum benefit (for Basic and Optional Employee Term Life Coverage combined) is $1,500,000. Amounts otherwise payable as benefits will be reduced by the amount of any Accelerated Benefits paid under the Option to Accelerate Payment of Death Benefits.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Optional Employee Term Life Coverage

You may enroll in one of the options below for optional term life coverage.

Benefit Classes	Amount of Insurance (Multiple of Annual Earnings)	
	Sum of Basic + Optional	Optional
Option 1	3x annual Earnings	1x annual Earnings
Option 2	4x annual Earnings	2x annual Earnings
Option 3	5x annual Earnings	3x annual Earnings
Option 4	6x annual Earnings	4x annual Earnings
Option 5	7x annual Earnings	5x annual Earnings

If the amount of your Basic Employee Term Life Coverage, when added to the amount of your Optional Employee Term Life Coverage, is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. However, the maximum benefit for Basic and Optional Employee Term Life Coverage combined is $1,500,000. Amounts otherwise payable as benefits will be reduced by the amount of any Accelerated Benefits paid under the Option to Accelerate Payment of Death Benefits.

Any requested change in coverage (increase or decrease) must be made within 31 days of a qualified life event or in connection with annual enrollment.

Notwithstanding the foregoing, the amount of your coverage may not exceed the "guaranteed issue amount" unless you submit evidence of insurability that is satisfactory to Securian and you are actively at work. The "guaranteed issue amount" is the lesser of (1) three times (3x) your annual Earnings, and (2) $500,000. Also, you must submit evidence of insurability if you are first applying for coverage under the Optional Employee Term Life Coverage Option during annual enrollment and your application is made more than 31 days after the date you first became eligible for coverage.

Without limiting the generality of the foregoing, you will need to provide evidence of insurability

- If you are a regular new hire or newly eligible for coverage and you apply for coverage under the Optional Employee Term Life Coverage Option in an amount greater than three times (3x) your annual Earnings (Basic plus Optional Coverage combined), or if the total amount of your Term Life Coverage after giving effect to your Optional Employee Term Life Coverage exceeds $500,000;
- If you are first applying for coverage under the Optional Employee Term Life Coverage Option during annual enrollment and the date you apply during annual enrollment is more than 31 days after your date of hire or the date you newly became eligible for coverage;
- If you are currently enrolled in the Optional Employee Term Life Coverage Option, you want to increase your coverage during annual enrollment, and the amount of your requested increase is greater than one times (1x) your annual Earnings, or the total amount of your Term Life Coverage after giving effect to your requested increase in coverage exceeds $500,000;
- If you request an increase in coverage due to a qualified life event and the amount of your requested increase is greater than one times (1x) your annual Earnings, or the total amount of your combined coverage under the Basic Employee Term Life Coverage Option and the Optional Employee Term Life Coverage Option (your "Employee Term Life Insurance") after giving effect to your requested increase in coverage exceeds $500,000;
- If you desire life insurance coverage and have an individual life insurance contract you obtained by converting your coverage under the Plan;
- The insurance for which you previously enrolled did not go into effect or was terminated because you failed to make a required premium contribution; and
- If you have not met a previous evidence requirement to become insured under any plan a Participating Employer has with Securian.

Any new enrollment or requested increase in coverage that is subject to evidence of insurability will become effective when Securian decides the evidence is satisfactory and you are actively at work; provided, however, that any such new enrollment or requested increase in coverage that is made in connection with annual enrollment will be effective on the later of (1) the following January 1, and (2) the first day of the month following the date Securian decides the evidence is satisfactory and you are actively at work.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any

lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option or the Optional Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor.

The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000. The maximum death benefit eligible for an Accelerated Benefit is $1,000,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

If you elect an Accelerated Benefit and the termination of your Employee Term Life Insurance causes an eligible dependent to lose life insurance coverage, he or she will be allowed to convert any such insurance to a policy of individual life insurance as discussed below under the section entitled "Conversion Privilege for Life Coverage."

If the amount of your Employee Term Life Insurance exceeds the maximum Accelerated Benefit, your Employee Term Life Insurance coverage (reduced by the amount of the Accelerated Benefit) will continue after your election of the Accelerated Benefit and your premiums will be reduced accordingly. The amount of the Accelerated Benefit will be applied first to reduce your outstanding Optional Employee Term Life Coverage and

then to reduce your outstanding Basic Employee Term Life Coverage.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Dependents Term Life Coverage

Under the Dependents Term Life Coverage Option, you may enroll your "eligible dependents" for coverage in the amounts shown below.

Your spouse who is an "eligible dependent"	
Benefit Classes	**Amount of Insurance**
Option 1	$10,000
Option 2	$25,000
Option 3	$50,000

Your children who are "eligible dependents"	
Benefit Classes	**Amount of Insurance***
Option 1	$5,000
Option 2	$10,000

You must provide evidence of insurability under the following circumstances:

- If you choose Option 3 spousal coverage (coverage in the amount of $50,000);
- If any dependent's coverage for which you previously enrolled did not go into effect under the Plan or was terminated because you did not pay a required contribution;
- If, during a previous period of eligibility, you failed to submit evidence of insurability that was required for a dependent or that which was submitted was not satisfactory to Securian; or
- Your dependent is insured by an individual policy issued under the terms of the conversion right.

Option 3 spousal coverage will become effective on the date Securian decides the evidence of insurability is satisfactory.

If a dependent (other than a newborn child) is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released form such hospitalization or confinement.

No enrollment or increases in coverage may become effective so long as your "eligible dependents" are confined for medical care or treatment, whether at home or elsewhere.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Payment of Death Benefits under Life Coverage

If you or your "eligible dependent" dies while covered under the Plan, the amount of insurance on you or your "eligible dependent" is payable when Securian's home office receives written proof satisfactory to it that you or your eligible dependent died while covered under the Plan and insured under the Group Insurance Certificate. If you or an "eligible dependent" die within 31 days after ceasing to be covered under the Plan, but while you or your "eligible dependent," as the case may be, are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of

insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules. Death benefits under the Dependents Term Life Coverage Option are payable to you, if you are living. If you are not living, benefits are payable to your estate.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance or your coverage under the Dependents Term Life Coverage Option terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features"* below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in an amount up to two times (2x) your annual "Earnings." If this amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit (for Basic and Supplemental Employee AD&D Coverage combined) is $1,500,000.

Supplemental Employee AD&D Coverage Option

You may enroll for supplemental employee AD&D coverage in any multiple of $10,000 up to the lesser of (1) ten times your annual Earnings, and (2) $1,500,000 minus the amount of your insurance under the Basic Employee AD&D Coverage Option).

Dependents AD&D Coverage Option

You may enroll for AD&D coverage on each of your "eligible dependents" in an amount equal to a percentage of your Supplemental Employee AD&D Coverage, as set forth below:

Eligible dependents	Amount of Insurance on each Eligible Dependent (as % of Employee AD&D Coverage)
Spouse only	60% on spouse
Child(ren) only	10% on each child
Spouse and child(ren)	50% on spouse; 10% on each child

Additional AD&D Coverage

The Plan provides additional benefits under the Basic, Supplemental Employee, and Dependents AD&D Coverage Options for a person's loss of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance on the person, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including

Reserve or National Guard active duty for training); (8) travel in or descent from any aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 59.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance and the Dependents Term Life Coverage Option, except that you or your "eligible dependent," as the case may be, may convert the amount of insurance under the Employee Term Life Insurance or the Dependents Term Life Coverage Option that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You and your eligible dependents are eligible to continue your Employee Insurance and Dependents Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date, but not more than $1,000,000 for an employee or $50,000 for a spouse. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date to a maximum of $650,000 for an employee or $32,500 for a spouse.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000. This minimum does not apply to a dependent.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) in the case of your dependent child or a spouse who is covered under the Plan, the date your coverage is no longer being continued under the Portability Plan or the date your spouse or child ceases to be eligible under the Plan; or

(4) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life, Optional Life, Dependent Life, be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No. except for conversion of Dependent Life	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

*Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at **1-888-640-3320**, or online via the Benefits Source website at* mysourceforhr.com. *If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process –Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Exempt Part-Time Employees Hired or Rehired On or After January 1, 2010

Contents

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of a NiSource Inc. ("NiSource" or "Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Life and Medical Benefits Program and the NiSource Welfare Benefits Program (collectively the "Program") each year.

The benefit information contained in this Handbook applies to all eligible regular part-time exempt employees hired or rehired on or after January 1, 2010 who work for the Company or a participating employer and who are covered under the Program. For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible employees as belonging to Active Benefit Program 107.

A participating employer is an affiliate of the Company that has adopted, or is deemed to have adopted, the Program, as evidenced by the Company's books and records reflecting that eligible employees of such employer may participate in certain of the benefits thereunder. The NiSource Benefits Committee (the "Committee") has sole discretion to determine who is a participating employer.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The Committee reserves the right to terminate, change or modify any plan provision at any time without the consent of, or advance notice to, you or your covered dependents, subject to the provisions of any applicable collective bargaining agreement.

The Program (or various component benefit plans thereof) also covers the following classes of employees, although benefits for such classes of employees are described in separate Handbooks and not herein: full-time exempt employees; part-time exempt employees; full-time non-exempt employees; part-time non-exempt employees; full-time employees who are members of certain collective bargaining units; part-time employees who are members of certain collective bargaining units; retirees who formerly were employees described in certain of the foregoing classes; and certain temporary work force and/or part-time status employees.

Benefit Plans At-a-Glance

NiSource offers you the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan" or a "Plan"). *(Details of each Benefit Plan can be found in the individual Benefit Plan sections of this Handbook.)*

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage (NiSource Dental Plan – referred to as the "Dental Plan")
- Vision Coverage (NiSource Vision Plan – referred to as the "Vision Plan")
- Flexible Benefits (NiSource Flexible Benefits Plan – referred to as the "Flexible Benefits Plan," and comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- Life and AD&D Coverages (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Accessing Benefits Information

You can access your benefits information through the Benefits Source, a website and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – 401(k).
- Other voluntary programs, including family counseling and referral services.

To access the Benefits Source, log on to the secure website at mysourceforhr.com. The website can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the Benefits Source automated telephone system at **1-888-640-3320.**

Definitions

Definitions Applicable to Medical, Dental, Vision and Flexible Benefits Plan

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Medical Plan, the Dental Plan, the Vision Plan, and the Flexible Benefit Plan, the following terms when used in this Handbook shall have the following meanings:

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended.

"Child" means a person who is

- a naturally born child;
- a legally adopted child or a child placed with a person for adoption;
- a stepchild;
- a foster child who is legally placed in a person's custody, for whom a person is providing parental care and for whom a person is legally responsible to provide medical care;
- a child for whom a person is legal guardian and who is dependent upon such person for at least 50% of his or her financial support and who may be claimed on such person's Federal income tax return (without giving effect to the child's gross income for the year); or
- a person deemed by a court order to be a child for purposes of coverage under a Benefit Plan.

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

"Co-Insurance" means the percentage of a covered expense that remains the responsibility of a person covered under a Plan, and does not include any Co-Payment.

"Co-Payment" means a flat dollar amount that a person covered under a Plan must pay before an expense will be covered.

"Deductible" is the amount of covered expenses that must be incurred by an individual or family in a Plan Year before a Plan will pay benefits.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement

under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

"Injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place, which results in damage to the body of a person covered under a Plan from an external force or contact.

"In-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"Medicare" means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended. It includes Medicare Part A (hospital insurance, including inpatient care in hospitals, skilled nursing facility care, and hospice care), Medicare Part B (medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health care and many preventive services), Medicare Part D (prescription drug coverage), and Medicare Part C (Medicare Advantage Plans, which bundle Medicare Part A and Medicare Part B coverage, and often Medicare Part D coverage).

"Medically Necessary" means a service or supply ordered or prescribed by a Provider that is appropriate for the diagnosis, care, or treatment of a Sickness or Injury. Such service or supply must be (1) as likely to produce a significant outcome as, and no more likely to produce a negative outcome than, any alternative; (2) indicated by your health status to result in information that could affect treatment, if a diagnostic procedure; (3) no more costly than any alternative; (4) provided in accordance with applicable medical and/or professional standards; (5) the most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); (6) not Experimental or Investigational; (7) not primarily for your convenience or for the convenience of your family or your Provider; and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Medical Plan SPD entitled "Maximum Allowed Amount."

"PBM" means the Pharmacy Benefit Manager for the Medical Plan. As of the date of this Handbook, the PBM is Anthem.

"Provider" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified surgical technologists, and registered nurse midwives, when working directly for a doctor of medicine. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Providers when acting within the scope of their license for services covered by the Plan. Each registered physical, occupational, respiratory, and speech therapist, psychologist, and social worker licensed under state law when providing a service covered by a Plan shall be deemed to be a Provider.

"Sickness" means an illness causing loss commencing while a Plan is in force for a person covered by the Plan. Sickness shall be deemed to include disability caused or contributed to by pregnancy, miscarriage, childbirth and recovery therefrom. Sickness shall only mean sickness or disease that requires treatment by a Provider.

Definitions Applicable to All Benefit Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program**

Overview and in the individual Benefit Plan sections, the following terms when used in this Handbook shall have the following meanings:

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

"Employer" means the Company or any Participating Employer by whom you are employed.

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

"Outbreak Period" means the period beginning March 1, 2020, and ending 60 days after (A) the announced end of the national emergency declared in (i) that certain Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak issued on March 13, 2020 by President Trump and (ii) that separate letter dated March 13, 2020, from President Trump to the Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency, in which the President made a determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Act that a national emergency exists nationwide beginning March 1, 2020, as a result of the COVID-19 outbreak, or (B) such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury in a future notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, or any other affiliate of the Company that participates in the Benefit Plan.

"Plan Administrator" means the NiSource Benefits Committee, and any person or entity to whom the committee has from time to time delegated authority to carry out the administrative functions of a Plan.

"Spouse" means a person who is treated as your spouse under the Code. ***Please Note:*** See "Eligibility under the Medical, Dental, and Vision Plans" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for medical plan coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Eligibility

General Information Concerning Eligibility

You and your eligible dependents *(as defined below or in the applicable individual Benefit Plan sections of this Handbook)* will be eligible to elect to participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan.

Please Note*:* It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including dismissal.* Also, enrollment of a dependent under the Medical Plan may be denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Please note that the Affordable Care Act requires us to collect the Social Security Number of each individual covered under the Medical Plan. Covered individuals may face a tax penalty for failure to provide this information. To report this information, please contact the Benefits Source at **1-888-640-3320**.

Eligibility under the Medical, Dental and Vision Plans

You and your eligible dependents may elect to participate in the Medical, Dental, or Vision Plans if you are actively at work and you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week.

Your eligible dependents include:

- Your Spouse, provided you are not legally separated;
- With respect to insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law, your former Spouse or your Spouse from whom you are legally separated;
- Your child who has not attained 26 years of age;
- Your unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) the child's disability arose before the date dependent status would otherwise have terminated; (2) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise have terminated; (3) the child is dependent upon you for financial support and maintenance; (4) you continue to be covered by the Plan; (5) with respect to the Dental or Vision Plan coverage, the child is also covered under the Medical Plan, or was covered under the Dental Plan and/or Vision Plan, as the case may be, as of December 31, 2018, and has remained covered under such Plan or Plans continuously since that date; (6) the child's disability continues; and (7) the child has not attained age 65;

Please Note: To maintain coverage, you must furnish proof of your child's disability to the Claims Administrator every three years, or more frequently as requested by the Claims Administrator. If the Claims Administrator determines that you have failed to furnish sufficient proof of your child's disability or if it determines that your child is no longer disabled, coverage for your child will cease.

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Medical, Dental or Vision Plan.*

Eligibility under the Flexible Benefits Plan

FSA Plan

You can elect to participate in the FSA Plan provided you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week. However, if you make contributions, or if contributions are made on your behalf, to an HSA during the Plan Year,

you may not elect to make contributions to a Heath Care FSA during such Plan Year.

For purposes of reimbursement of eligible expense under the Health Care FSA, your eligible dependents include your Spouse or persons who qualify under the Code as your tax dependents for health coverage purposes.

For purposes of reimbursement of eligible expenses under the Dependent Care FSA, your eligible dependents include:

- Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child;
- Your Spouse who is physically or mentally incapable of caring for himself or herself, provided the Spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, your Spouse must regularly spend at least eight hours each day in your home;
- Any other person, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year. This includes a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step–daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.

HSAs

You can elect to contribute to a health savings account("HSA") if you are characterized as a regular part-time employee of a Participating Employer who regularly works less than 40 hours per week and who is enrolled in either the HDPPO 1 or HDPPO 2 option. Contributions to an HSA can only be made when enrolled in an HDPPO. You cannot contribute to an HSA or receive Employer contributions if you have coverage under any other health plan that is impermissible coverage for purposes of Section 223 of the Code.

Please note: *You may not contribute to your HSA and the Health Care FSA at the same time.*

The limitation on the amount you may contribute to an HSA is determined on a monthly basis. The monthly contribution limit is zero for any month in which you are enrolled in Medicare. Please note that if you first apply for Medicare benefits after you attain age 65, your Medicare enrollment will be retroactive to a date that is six months prior to the month in which you apply for benefits, but not earlier than the first month you were eligible for Medicare. Thus, your monthly HSA contribution limit may be zero for a number of months that precede your application for Medicare benefits. It is your responsibility to make sure your HSA contributions do not exceed the maximum amount permitted under the Code. Please consult your tax advisor if you have questions regarding the amount you may contribute to an HSA, including for the months leading up to your application for Medicare benefits.

Please refer to the Benefits Source website at mysourceforhr.com*, or call the Benefits Source automated telephone system at* ***1-888-640-3320*** *if you are unsure of whether you are eligible to participate in the Flexible Benefits Plan.*

Eligibility under the Life and AD&D Plan

Employees

You are eligible to participate in the Life and AD&D Plan if you (i) are a regular part-time employee of a Participating Employer, (ii)

regularly work less than 40 hours per week, and (iii) are actively at work. You are actively at work if you are fully performing your customary duties for your regularly scheduled number of hours at your Employer's normal place of business, or at other places your Employer's business requires you to travel. Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

Enrollment

General Information Concerning Enrollment

When you first become eligible to participate in a Benefit Plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents.

Generally, to be covered, you must initially enroll for the medical, dental, flexible benefits, and vision coverages within 31 days following the date on which your enrollment materials are sent to you. **(This Benefits Program Overview or the individual Benefit Plan sections of this Handbook contain additional information about enrollment in each Plan.)**

You are automatically enrolled for EAP/Work Life/Legal & Financial Services (regardless of whether you enroll in PPO, HDPPO or HMO coverage under the Medical Plan), basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll in coverage that is not provided automatically, you must log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320.**

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable **(the deadline date is included in the enrollment materials)**, you will automatically receive default coverage **(as described in this Benefits Program Overview or in the applicable individual Benefit Plan section of this Handbook)**, if applicable, for the remainder of that calendar year.

> **Please Note:**
>
> Dependents will not be eligible to receive any of the benefit coverages if you fail to enroll them during your initial 31-day enrollment period, during any subsequent annual enrollment or within 31 days following a qualified life event.

Enrollment in the Medical, Dental, and Vision Plans

Provided you meet the eligibility requirements, as described in the section above entitled "*Eligibility under the Medical, Dental and Vision Plans*", you and your eligible dependents can participate in the Medical Plan, Dental Plan and/or Vision Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. If you fail to enroll, you will be deemed to have elected (i) the HDPPO 1 medical option with no dependent coverage under the Medical Plan, (ii) the Preventive Dental option with no dependent coverage under the Dental Plan, and (iii) the Basic Vision option with no dependent coverage under the Vision Plan. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. If you do not enroll or elect to change coverage, if applicable, within the annual enrollment period, your current coverage will remain in effect for the upcoming Plan Year, if available, at the applicable rates. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of this **Benefits Program Overview** for further details.

Please Note:

If you do not enroll in the Medical Plan, Vision Plan or Dental Plan within 31 days of your initial eligibility date, your next opportunity to enroll or change elections will not be until the next annual enrollment period or until you experience a qualified life event that would permit your enrollment. Also, if you do not enroll an eligible newborn child for coverage within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or the next qualified life event that permits the child's enrollment.

Enrollment in the Flexible Benefits Plan

FSA Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Flexible Benefits Plan,*" you may participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire Plan Year. In addition, participation in the FSA Plan requires annual enrollment, at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

HSAs

To enroll in an HSA, you must meet the following requirements:

- You must be enrolled in HDPPO 1 or HDPPO 2.
- You cannot be covered by another medical plan (e.g., you cannot be a dependent on anyone else's plan, except for vision and dental coverage) that is not a high deductible health plan.
- You cannot be enrolled for Medicare benefits. (Part A or Part B)
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be covered by a general-purpose Health Care Flexible Spending Account, including the Health Care FSA

You must satisfy any requirements or conditions for establishing or activating your HSA that are prescribed by the Claims Administrator for HSAs. Failure to do so may result in the delay or failure to receive an employer HSA contribution to which you might otherwise be entitled.

Enrollment in the Life and AD&D Plan

Provided eligibility requirements are met, as described in the "*Eligibility under the Life and AD&D Plan*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option (collectively referred to as "Employee Life and AD&D Insurance").

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Elections"* subsection of this **Benefits Program Overview** for details.

Dual Coverages

If you and your dependent(s) (Spouse or child) are eligible for Program benefits as active or retired employees of NiSource or one of its affiliates, any of you may choose coverage either for yourselves only or for yourselves and your eligible dependents. However, for most Program benefits, it is not possible to be covered by more than one NiSource Benefit Plan of the same type (e.g., more than one medical plan). Also, for most Benefit Plans, a NiSource active or retired employee cannot be covered under the Benefit Plan both as a participant and as a dependent. Likewise, if you and your Spouse are both employees of NiSource or one of its affiliates, either of you may choose to cover your child(ren); however, it is not possible for both of you to cover your

child(ren) under the same plan. Double benefits are not available.

If your covered dependent becomes employed by an Employer and either timely elects coverage under the Medical, Dental, and/or Vision Plans, or makes no coverage election and is thereby deemed to have elected coverage under such Plans, you will be deemed to have requested that coverage be dropped for such dependent under the Medical, Dental, and/or Vision Plans, as the case may be.

Coverage under the Program for retired employees or for active employees other than the eligible employees for whom this Handbook is prepared is described in separate Handbooks and not herein.

Enrollment Pursuant to a Qualified Medical Child Support Order

The Program also provides medical, prescription drug, vision, and dental coverage for your eligible child (as well as participation in the Health Care Flexible Spending Account, to the extent the child is a tax dependent for health coverage purposes under Federal law) pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). This may apply even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or a Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

Additionally, your Employer may withhold from your wages any contributions required for such coverage.

You may obtain from the Company, without charge, a copy of the Benefit Plans' QMCSO procedures.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. If you do not enroll within the annual enrollment period, your current coverages generally remain in effect for the upcoming Plan Year, if available, at the applicable rates.

You will be advised of any new benefit plans, plans that require enrollment and the deadline date. **However, if you want to participate in the Health and/or Dependent Care Flexible Spending Accounts or in a Health Savings Account (HSA), you need to elect to participate each year. Your Flexible Spending Account and Health Savings Account contribution elections will not carry over from one Plan Year to the next.**

If you add a new dependent to Benefit Plan coverage during annual enrollment, you must provide the dependent's social security number to the Benefit Plan by calling the Benefits Source at **1-888-640-3320** or by visiting the Benefits Source website at mysourceforhr.com,

In the event your current Medical, Dental, or Vision Plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "*Enrollment in the Medical, Dental, and Vision Plans*" for further details.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Medical Plan at your home address.

The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact Anthem, in the case of the PPO or HDPPO options, or, if applicable, your HMO in the case of an HMO option.

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverage Begins and Ends - General

Please see below for a complete description of when the coverage begins and ends with respect to each Benefit Plan.

When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans

Coverage Begins

Generally, coverage under the Medical Plan, Dental Plan, Vision Plan, or FSA Plan may become effective, if you properly enroll, (1) on your first day of active employment for regular new hires, (2) on the first day of the following Plan Year for eligible employees who enroll during the annual enrollment period, or (3) on the date the Plan approves your enrollment based upon a qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation on or after January 30, 2020 (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan will end on the earliest of (i) the date the Plan is terminated, or (ii) the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends on the earliest of the following dates:

- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and except as provided by the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The end of the month following the date an employee terminated employment.

In addition, coverage under the Health Care FSA will cease if an HDPPO coverage option is elected under the Medical Plan.

A dependent shall cease to participate in the Medical Plan, the Dental Plan, the Vision Plan, and the FSA Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends (except that, in the case of the employee's death, a dependent shall cease to participate in the Plan on the last day of the month in which the employee dies) (see also the section below entitled "*Survivor Coverage"* for circumstances under which coverage under the Medical Plan for an eligible surviving dependent may continue beyond an employee's death);
- The last date for which any required contributions for the dependent's coverage was made;
- For a Spouse, the date of divorce or legal separation, except in the case of insured Medical Plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, but only to the extent and for as long as required by applicable state law;
- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if you or your eligible dependents experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will cease one day after the maximum COBRA continuation coverage period would otherwise expire on account of such qualifying event. See the section below entitled "*COBRA*" for an explanation of what constitutes a COBRA qualifying event.

When Coverage Begins and Ends - HSA

Coverage Begins

You may enroll in an HSA at any time provided you have properly enrolled in either the HDPPO 1 or HDPPO 2 option.

Coverage Ends

Your contributions to an HSA through the Flexible Benefits Plan will terminate as follows:

- The date on which the Plan terminates;
- The date you are no longer eligible;
- The date you are no longer actively at work; or
- The date on which you request that your contributions cease or that the HSA Account be closed.

If you are no longer enrolled in HDPPO 1 or HDPPO 2 or you have terminated employment or retired, you will be required to pay a monthly account fee to the HSA Trustee/Custodian for as long as money remains in your HSA. You will also receive a new HSA debit card that will allow you to continue using the remaining money in your account for qualified medical expenses.

When Coverage Begins and Ends – Life and AD&D Plan

Coverage Begins

Provided you have satisfied the eligibility requirements described above under the section *"Eligibility under the Life and AD&D Plan,"* coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the Life and AD&D Plan may generally become effective on the first day you are actively at work, if you are a regular new hire, or on the first day you are newly eligible for coverage, provided you are actively at work on such day.

If you are not actively at work on the date coverage would otherwise begin, you will not be eligible for the coverage until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided herein or in the group insurance contracts (collectively, the "Group Contract") or group insurance certificates issued by Securian, you are eligible to continue to be insured only while you remain actively at work.

Coverage Ends

Your Employee Life and AD&D Insurance will end when the first of these occurs:

- The date as of which the Life and AD&D Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Life and AD&D Coverage Option, the date such Life and AD&D Coverage Option is terminated;
- The date that the Life and AD&D Plan or Group Contract is amended to terminate coverage for you or to make you no longer eligible;
- The last day of the month in which you terminate employment or are otherwise no longer eligible for coverage under the Plan as a regular part-time employee or as a member of another eligible class;

If your Employee Life and AD&D Insurance terminates because of non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by the Claims Administrator within 31 days of the date of termination and during your lifetime.

Provided your coverage has already commenced, your coverage may be continued if you are not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to your Employer's practices and procedures.

If you stop active part-time work for any reason, you should contact the Company or your Employer at once to determine what arrangements, if any, have been made to continue any of your insurance coverage, or

whether you belong to another class of employees that may be eligible for coverage under the Plan.

Changing and Continuing Elections

General

In general, once you enroll for (or decline) coverage, your elections stay in effect in the entire Plan Year. However, the Internal Revenue Service will allow you to enroll for or change certain pre-tax elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain pre-tax elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, or the Flexible Benefits Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator. In addition to satisfying any requirements established by the applicable Benefit Plan and any insurer (with respect to insured coverage), any requested change in election must satisfy all requirements imposed by the Internal Revenue Service.

To the extent permitted by the applicable Benefit Plan, if you experience a qualified status change, you may elect a different category of coverage (e.g., no coverage, employee only, employee + spouse, employee +family) if that new election is on account of, and corresponds with, your qualified status change and if the new election satisfies other Internal Revenue Service consistency rules.

Examples of qualified status changes include any of the following circumstances that may affect eligibility for coverage under one of the Benefit Plans listed above:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).

Please Note:

If you do not request a change in election within 31 days of your qualified status change or other qualified life event, your next opportunity to change elections will not be until the next annual enrollment period or until you experience another qualified life event. For example, if you do not enroll an eligible newborn child within 31 days of the child's birth, even if you do not have the child's social security number, your next opportunity to enroll the child will not be until the next annual enrollment period, unless you experience another qualified life event that would permit you to change elections.

Other qualified life events that may permit a change in your elections (including a change in category of coverage and, in some instances, a change in coverage option) include the following:

- You, your spouse, or your dependent experiences a significant change in cost or coverage of a Benefit Plan (this does not apply to the Health Care Flexible Spending Account).
- With respect to the Medical Plan only, you qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For example, you may qualify for special enrollment if (1) you acquire an eligible dependent after your employment begins, (2) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) lose coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage, or (3) you (or your dependent) lose coverage as a result of loss of eligibility under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, or you (or your dependent) become eligible for assistance, with respect to coverage under the Medical Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***
- The Benefit Plan receives a Qualified Medical Child Support Order ("QMCSO") or other court order, judgment, or decree that requires you to enroll a dependent child in an accident or health plan.
- With respect to accident or health plan coverage, you, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You or your eligible dependents lose coverage under any group health coverage sponsored by a governmental or educational institution,
- You take leave under the Family and Medical Leave Act.

If a dependent you are covering under the Medical, Dental or Vision Plan is hired by an Employer and either timely elects coverage under such Plan or fails to make a timely coverage election and is thereby deemed to have elected a coverage option thereunder other than the "No Coverage" option, you will be deemed to have elected to drop Plan coverage for such dependent in connection his or her change in employment status.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the Benefit Plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan section for

details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that cover you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any other benefits (apart from those under individual or private insurance plans) to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then – based on what the primary plan pays – the other (**secondary**) plans may pay a benefit (if any).

If your coverage under the applicable Benefit Plan is primary, the Benefit Plan pays the amount payable under such plan.

If your coverage under the applicable Benefit Plan is secondary, the primary plan pays its benefits first. Then, the secondary benefit plan pays the lesser of:

- The amounts payable under the secondary benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the Benefit Plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary. 98

In the case of a divorce or separation, the following order will establish responsibility for payment:

— If there is a court order that requires a parent to take financial responsibility

for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.

- The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.
- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.
- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If, after using the guidelines above, a determination cannot be made as to the order of payment, the plan that has covered the person longer is the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. However, if one of you has been entitled to Social Security disability benefits for 25 months as an insured individual, child, widow, or widower who is "under a disability," that person may become Medicare-eligible before age 65.

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits.

How Coordination of Benefits Works for Those in "Current Employment Status"

If you are in "current employment status" within the meaning of Medicare regulations, and if you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this Handbook, and Medicare is secondary); or
- Coverage under Medicare only (if that is what you have elected).

Please Note:

End-Stage Renal Disease. If you or your covered dependent enroll in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary at the time you or your covered dependent enroll, the Medical Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

If you are in "current employment status" and you and your Spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan, in which case Medicare would be the primary carrier. Your Spouse may, if age 65 or older, make a separate Medicare election. However, your Spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

How Coordination of Benefits Works for Those Not in "Current Employment Status"

If you are covered under the Medical Plan but are no longer considered in "current employment status" for purposes of Medicare, and you and your spouse are Medicare-eligible, then Medicare is the primary payor regardless of your or your covered spouse's age. You are responsible for notifying the Claims Administrator if you, your Spouse, or your other eligible dependents become Medicare-eligible.

If you are not in "current employment status" and if a covered person is eligible for, but not enrolled in, Medicare benefits,

the Medical Plan will deduct from the amount otherwise payable with respect to a claim the amount Medicare would have paid had that person been enrolled in Medicare or in any part thereof. (However, no deduction will be made for failure to enroll in Medicare Part D prescription drug coverage.) For example, if you are not in "current employment status" and are eligible for, but not enrolled in, Medicare Part B, and if you incur a claim that would be payable in whole or in part by Medicare Part B, the Medical Plan will deduct from the amount it would otherwise pay for such claim the amount Medicare Part B would have paid.

Please Note:

Late Enrollment Penalties for Medicare Parts B and D. If you are eligible for Medicare by reason of age or disability, are no longer in current employment status for purposes of Medicare, and do not enroll in Medicare Part B or Medicare Part D during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage. For more information concerning Medicare late enrollment penalties, see the Medicare & You publication at https://www.medicare.gov/medicare-and-you or contact your local Social Security Administration office.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Medical Plan and Medicare Part D at the same time, such coverage will coordinate as provided by law.

How Coordination Works With TRICARE

If you are a TRICARE beneficiary, your coverage under TRICARE will coordinate with group health plan coverage under the Program as provided by law.

Claim Determination and Appeal Process - General

General

The Committee delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section of this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

In certain cases, the Plan Administrator or its designee may decide claims requiring a determination of whether you meet the requirements for eligibility under the terms of the applicable plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's or Plan Administrator's determination if your claim has been denied (in whole or in part).

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

You may have someone else represent you in any of the review processes as long as you provide written notice to the Claims Administrator or Plan Administrator, as appropriate, of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, or SPDs, please see below or the individual Benefit Plan sections of the Handbook.

Discretion and Authority of Plan Administrator and Claims Administrator

See the subsection entitled "Named Fiduciary and Plan Administrator" under the "Additional Information" section below for information concerning the discretionary authority of the Plan Administrator, the Claims Administrator and the NiSource Benefits Department to interpret the various Benefit Plans and to make determinations thereunder.

Legal Action

You cannot bring any legal action against a Benefit Plan unless you first complete all required steps of the applicable appeals process described in this Handbook. Once you complete that process, you can bring legal action against the applicable Benefit Plan. If you decide to take legal action, you must do so before the deadline, if any, specified below or in the applicable individual Benefit Plan section of the Handbook.

Claim Determination and Appeal Process – Medical Plan

The claim determination and appeal process described below applies to the Medical Plan. The term "Plan" as used in this section refers to the Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (ii) a rescission of coverage.

A "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay on a timely basis premiums or contributions towards the cost of coverage.

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide

should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may obtain a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or jeopardize the ability of the patient to regain maximum function, or in the opinion of the patient's doctor with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of this claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The Claims Administrator's receipt of the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is that of an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and consider the claim according to the post-service or pre-service time frames, whichever applies.

Full and Fair Review

In connection with a claim or internal appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date. In addition, before you receive a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of a final internal adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim or Rescinds Coverage

If you receive a notice of an adverse benefit determination, the notice will:

- Include information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the determination is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal, as well

as a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals;

- In the case of an urgent care claim, describe the expedited review process applicable to such claims; and
- To the extent required by applicable regulations, disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Mandatory First-Level Internal Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim or rescission of coverage, you or your duly authorized representative have the right to appeal the adverse benefit determination by sending a written request for review to the Claims Administrator within 180 days of your receipt of notice of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied or your coverage under the Plan should not have been rescinded. Your request also should include the name of your Employer, any adverse benefit determination letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the adverse benefit determination was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or

vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you or your duly authorized representative may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Mandatory First-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal (for the Medical Plan, this determination will constitute a "final adverse benefit determination"), it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical

necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

Second-Level Internal Appeal to the Claims Administrator

If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal with respect to your pre- or post-service claim or a rescission of coverage, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for a second-level internal appeal to the Claims Administrator within 60 days of your receipt of the Claims Administrator's notice of denial of your mandatory first-level internal appeal.

This second-level appeal is a voluntary appeal. That means you are not required to request a second-level internal appeal under the Plan before submitting a request for an independent external review. However, if you request a voluntary second-level internal appeal under the Plan, you must receive a determination on that appeal before requesting an independent external review.

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The Medical Plan agrees that any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated second-level voluntary internal appeal is pending. The Claims Administrator will, upon request, provide you with information relating to the voluntary second-level internal appeal to enable you to make an informed judgment about whether to request such an appeal. Your decision whether or not to request a voluntary second-level internal appeal under the Medical Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Medical Plan.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request also should include the name of your Employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial of your claim on appeal was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of

any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Internal Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level internal appeal, it will notify you of the following, in a manner to be understood by you:

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Voluntary External Review by Independent Review Organization

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, a rescission of coverage or your mandatory first-level internal appeal or second-level internal appeal, you may be entitled to obtain an independent external review pursuant to Federal law, as provided below. External review applies only to an adverse benefit determination (including a final internal adverse benefit determination) by the Claims Administrator that involves medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). External review is not available in connection with an adverse benefit determination based

upon a determination that you fail to meet the requirements for eligibility under the terms of the Plan. You do not need to pursue an external review in order to complete or exhaust the appeal procedure described above. Your decision to seek an independent external review will not affect your rights to any other benefits under the Plan. Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Standard External Review

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described below).

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

Within five business days following the date your external review request is received, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination involves medical judgment or a rescission of coverage and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust such process under applicable federal regulations;
- You have provided all the information and forms required to process an external review.

Within one business day after completion of its preliminary review, the Claims Administrator will notify you in writing of the results of such review. If the request is complete, the Claims Administrator will assign an accredited independent review organization ("IRO") to conduct the external review.

The assigned IRO is required to notify you in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of your receipt of such notice, you may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to provide the documents and information on a timely basis, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. The IRO will notify you and the Plan within one business day after making any such decision.

Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to you and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

The IRO is required to review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

The assigned IRO is required to provide written notice of the final external review decision within 45 days after it receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

The assigned IRO's decision notice on external review will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

If the Claims Administrator makes an adverse benefit determination with respect to your initial claim, and your claim is an urgent care

claim or a concurrent care claim, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

You or your duly authorized representative may request an expedited external review orally or in writing. All necessary information for the review, including the Claims Administrator's determination, may be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

Upon receipt of your request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator will notify you in writing of the results of such review.

If the Claims Administrator determines that your request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review your claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO is required to notify you of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO is required to provide written confirmation of the decision to you and to the Plan.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Dental Plan, the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to the Dental Plan, the Vision Plan or the Health Care FSA, as the case may be, and the term "Claims Administrator" refers to the claims administrator appointed for the respective Plan.

The type of claim that you make determines the time frame under which the Claims Administrator will make a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Plan.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator will decide your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim but do not provide sufficient information for the Claims Administrator to make a determination, you will be notified within five days after your pre-service claim is received of the specific information necessary to complete the claim. Once you receive this notice, you then have 45 days to provide any needed information.

Post-Service Claims

Generally, a "post-service claim" is any claim that is not an urgent care claim, a pre-service claim or a concurrent care claim.

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Claims Administrator may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the

Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information.

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Unless you have failed to provide sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives your urgent care claim. The Claims Administrator will take into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent care claim but have not provided sufficient information to permit a determination of whether, or to what extent, benefits are covered or payable under the Plan, you be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If you are asked to provide specific information to complete your urgent care claim, you will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Claims Administrator receives the specified information; or
- The end of the period that you have to provide the specified additional information.

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the Benefits Source Participant Advocacy service through the Benefits Source toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving (i) a decision to reduce or terminate an ongoing course of treatment to be provided over a period of time or number of treatments, or (ii) a decision regarding your request to extend a course of treatment beyond the period of time or number of treatments that has been approved.

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request is an urgent care claim (as defined above), the Claims Administrator will decide your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment is not an urgent care claim, the Claims Administrator will treat your claim as either a pre-service or post-service claim (as applicable) and will consider the claim according to the post-service or pre-service time frames, whichever applies.

If the Claims Administrator Makes an Adverse Benefit Determination Regarding an Initial Claim

If you receive a notice of adverse benefit determination, the notice will:

- Explain the reasons for the adverse benefit determination;
- Describe any additional material or information necessary for you to complete your claim and explain why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based;
- Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals; and
- In the case of an urgent care claim, describe the expedited review process applicable to such claims.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim, the Claims Administrator will provide a description of the expedited review process for urgent care claims (as set forth below). The Claims Administrator may provide an oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

First-Level Appeal to Claims Administrator

If the Claims Administrator makes an adverse benefit determination regarding an initial claim, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan or FSA Plan, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a

health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the determination on review, will be transmitted between the Claims Administrator and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

You will be notified of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Makes an Adverse Benefit Determination on Your First-Level Appeal

If the Claims Administrator makes and adverse benefit determination on your first-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the

determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

If the Claims Administrator denies an urgent care claim on review, the Claims Administrator may provide oral notice of its determination, then follow-up with a written or electronic confirmation within three days.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Second-Level Appeal for Pre-and Post-Service Claims

If the Claims Administrator makes and adverse benefit determination with respect to your pre- or post-service claim on appeal, you or your duly authorized representative may request a review of such determination by the Claims Administrator by sending a written request for review within 60 days of your receipt of the Claims Administrator's notice of adverse benefit determination.

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the Dental Plan, the Vision Plan, or the Health Care FSA, as the case may be.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your request must include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your request, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, you will be notified of the determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, you will be notified of the determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Claims Administrator Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the Claims Administrator makes an adverse benefit determination on your second-level appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process - Dependent Care FSA

The claim determination and appeal process described below applies to the Dependent Care FSA Plan. As used in this section, the term "Claims Administrator" refers to the claims administrator appointed for the Dependent Care FSA Plan. The term "Plan" as used in this section refers to the Dependent Care FSA Plan.

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan, or a matter for which the Claims

Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for the Flexible Benefits Plan.

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If, because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your request for review within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you may be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied or deemed to have been denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial or deemed denial.

Upon receipt of your request, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written request for review is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension. If the Claims Administrator does not respond to your claim for benefits within the requisite time, your claim will be deemed denied.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; and (3) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Second Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Claims Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which

event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (1) the specific reason or reasons for the decision; (2) specific reference to the Plan provisions upon which the decision is based; and (3) a statement that you are entitled to receive upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Claim Determination and Appeal Process – Life and AD&D Plan

The claim determination and appeal process described below applies to the Life and AD&D Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" means a claim for accelerated death benefits, for accidental dismemberment benefits, or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Please Note: The Outbreak Period (defined above) will be disregarded in determining the period within which individuals may file a benefit claim or an appeal of an adverse benefit determination under the claims procedures described below.

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for

matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary, and
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the

written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator shall provide to you upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In connection with a claim for disability benefits, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided in advance of the date on which a notice of an adverse benefit determination is required to be provided. In addition, before you receive an adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to you, free of charge, the rationale. The rationale will be provided in advance of the date on which a notice of the adverse benefit determination on review is required to be provided.

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA

following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, the Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana.

Continuation of Coverage under the Medical, Dental, Vision and FSA Plans

General

Generally, coverage under the Medical, Dental, Vision and FSA Plans is only available to you if you are actively at work. However, if the Company or a Participating Employer under its personnel policies continues to treat you as an employee after you cease to be actively at work due to any of the following leaves, then you will continue to be treated as an employee eligible to participate in one or more of the Plans described above, subject to the terms and conditions of each such Plan.

Provided, however, your participation will cease as of the earliest of the dates set forth above under "*When Coverage Begins and Ends under the Medical, Dental, Vision and FSA Plans – Coverage Ends*." The leaves referred to above are:

Family and Medical Leave Act ("FMLA") Leave – Coverage under the Medical, Dental and Vision Plans for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family and Medical Leave Act ("FMLA"). However, you may revoke your health benefit elections upon the commencement of your FMLA leave of absence. If you return from an unpaid FMLA leave of absence after having revoked health benefit elections on account of taking FMLA leave, you may reinstate your elections on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. If your health benefit elections are revoked for non-payment of premiums during an approved FMLA leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

The Company and the applicable Participating Employer may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company or the applicable Participating Employer may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

You may continue to participate in the Health Care FSA and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave by pre-paying with pre-tax dollars any contributions due for coverage during the Plan Year in which your leave commences. You have the option to continue to participate in the Health Care FSA during your FMLA leave on an after-tax basis by making payments according to the same schedule in effect before your leave. If your participation in a Flexible Spending Account ceases on account of your leave, you may still use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. Also, if you ceased participation in the Health Care FSA during your leave, you may resume participation upon return from leave during the same Plan Year and either make up the unpaid contributions or resume coverage at a reduced level under the proration rule, with payments at your original contribution level.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under a Plan during the period of your service to the extent provided by USERRA and the NiSource Military Leave of Absence Policy. Without limiting the generality of the foregoing, if your health benefit elections are revoked for non-payment of premiums during an approved military leave of absence, such coverage may be reinstated on a prospective basis upon application to the Plan in connection with a return from leave, to the extent required by applicable law.

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental and Vision Plans and under the Health Care FSA (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."*

COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other

coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event or determination of disability.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a Spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage by reason of a disability (as described below), you may be required to pay up to 150 percent of the full cost of the coverage. (This extended coverage does not apply to the Health Care FSA.) These costs are subject to change.

You will have 60 days to elect COBRA (measured from the later of your coverage loss date or the date the Plan Administrator notifies you of your right to elect COBRA coverage).

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary on account of coverage under a Plan if you lose your coverage under such Plan because either one of the following qualifying events happens:

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

Your Spouse will become a qualified beneficiary on account of coverage under a Plan if he or she loses coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries on account of coverage under a Plan if they lose coverage under such Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;

- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You become divorced or legally separated; or
- Your child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

Each Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or reduction of hours of employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

[This paragraph applies only to the Medical, Dental and Visions Plans. It does not apply to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended (as described below). When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 18 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 18 months after the date of the qualifying event (36 months minus 18 months).

[This paragraph applies only to the Health Care FSA.] COBRA continuation coverage is a temporary continuation of coverage. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care FSA, you may continue your current contributions

to your Health Care FSA on an *after-tax* basis through COBRA only for the remainder of the Plan Year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care FSA option of the FSA Plan allows you to continue to incur and seek reimbursement of eligible claims for the remainder of the Plan Year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

[This paragraph does not apply to the Health Care FSA.] If you or anyone in your family covered under a Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) (i) within 60 days of the later of the date of the disability determination by Social Security and the date the qualified beneficiary loses coverage under the Plan as a result of your termination or reduction of hours of employment, and (ii) before the end of the initial 18-month period of COBRA continuation coverage, you and the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If proper notice is not provided within the 60-day period and before the end of your initial 18-month period of COBRA continuation coverage, you will not be entitled to a disability extension. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

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

[This paragraph does not apply to the Health Care FSA.] If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator within 60 days of the date of the second qualifying event. If proper notice is not provided within the 60-day period, you will not be entitled to an extension on account of the second qualifying event. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if your dependent child stops being eligible under a Plan as a dependent child, but only if the event would have caused your Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is the termination of your employment, COBRA continuation coverage for you, your Spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage may be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your Spouse and dependent children who lose coverage due to the divorce or legal separation, if notice of such event is properly given to the Plan Administrator.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months, in the case of the Medical, Dental and Vision Plans, or the remainder of the Plan Year, in the case of the Health Care FSA), COBRA continuation coverage for a qualified beneficiary will end on the earliest to occur of the following:

- The date such qualified beneficiary first becomes entitled to benefits under Medicare.
- The date on which all employers participating in the Program cease to

provide any group health plan or coverage to any employee.

- If you fail to make a required contribution (coverage will end at the end of the period for which the last contribution was made).
- Provided such date is after the initial 18-month COBRA period and no other extension of such period (other than the disability extension) applies, the first day of the month coincident with or next following 30 days from the date the Social Security Administration determines that a qualified beneficiary is no longer disabled.
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at **dol.gov/ebsa** (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Employee's death at any time on or after January 1, 2004, if COBRA continuation coverage has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Employee's surviving dependents who are covered under the Medical Plan on the date of that Employee's death, then coverage under the Medical Plan for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Employee's surviving spouse dies, (ii) the last day of the month in which the Employee's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer with whom the Employee was employed ceases to be a "related employer," as defined in the Medical Plan.

If medical coverage under the Medical Plan ends for an Employee's dependent because of such Employee's death within 30 days preceding, or at any time on or after, May 1, 2010, and if such Employee would have satisfied the conditions for eligibility for retiree medical coverage under the Medical Plan or the NiSource Post-65 Retiree Medical Plan had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the Medical Plan at the time of the Employee's death, the Employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and have been a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date) or the NiSource Post-65 Retiree Medical Plan (in an available coverage option selected by the dependent), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Medical Plan. An eligible surviving dependent of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the NiSource Post-65 Retiree Medical Plan.

If survivor coverage under the Medical Plan will end for a surviving dependent of a Deemed Retiree solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the NiSource Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Medical Plan or the Dental Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any

other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by you or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- A worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the illness, sickness or bodily injury. When this happens, the applicable Benefit Plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable Benefit Plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable Benefit Plan may recover any sums paid under such Benefit Plan on behalf of the covered person;
- Recover from the covered person or his or her legal representative any benefits paid under the applicable Benefit Plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable Benefit Plan, the covered person agrees, and will cause his or her legal representative to agree, to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable for the Benefit Plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements, or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust of r the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the illness, sickness or bodily injury. The applicable Benefit Plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- The amount recovered from the Other Party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the applicable Benefit Plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- The covered person or his or her legal representative will be personally liable to the applicable Benefit Plan for the amount of the benefits paid under that Benefit Plan; and
- The applicable Benefit Plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable Benefit Plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable Benefit Plan's attorney fees and court costs, are the responsibility of the covered person, not the Benefit Plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Benefit Plan, and as a condition of participating in the Benefit Plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to

any funds recovered from the Other Party by or on behalf of:

- The employee;
- The employee's covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

If it becomes necessary for the applicable Benefit Plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the Benefit Plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If a Plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an in-network provider rather than an out-of-network provider. For the Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected

Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any Benefit Plan does not ensure you of continued (or renewed) employment with the Company, a Participating Employer, or any of their affiliates. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions;

and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though an Employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer, or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company, the Participating Employers, or their affiliates or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

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

Receive Information About Plan and Benefits

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

Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan 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, DC 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.

Certain Benefit Plans and Accounts Not Subject to ERISA

Notwithstanding anything to the contrary contained in this Handbook, neither the Dependent Care FSA nor the HSAs (to which contributions are made through the Flexible Benefits Plan) are employee benefit plans subject to ERISA.

Consolidated Flex Medical Plan

PPO Plan

High Deductible PPO 1

High Deductible PPO 2

HMO

Your Medical Plan Options

This is the SPD (the "Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Medical Plan. In this Medical Plan SPD, the Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible employees and their eligible dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where a NiSource HMO option is available. *If this option is available to you and you elect the option, your insurer will provide you with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and co-insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual deductible. After you meet your deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA). The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all states. Please visit the map at livehealthonline.com for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at livehealthonline.com or download the app. To learn what mobile devices are supported and to get instructions, go to livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email **help@livehealthonline.com** or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are

covered the same way as any other medical expenses, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Medical Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Medical Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"ID Cards"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;
- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	PPO	
	In-Network (or out-of-area)	**Out-of-Network**
Calendar Year Deductible†	**You Pay**	**You Pay**
Covered Member	$500 per covered member	$1,000 per covered member
Covered Member + Spouse	$500 per covered person	$1,000 per covered person
Covered Member + child(ren)	$500 per covered person, up to a total of $1,000	$1,000 per covered person, up to a total of $2,000
Covered Member + Family (spouse + children)	$500 per covered person, up to a total of $1,500	$1,000 per covered person, up to a total of $3,000
Office Visit Co-Pay/Co-insurance	$35	40% after deductible
Specialist Office Visit Co-Pay/Co-insurance	$40	40% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes deductible and co-pay)		
Covered Member	$1,500	$3,000
Covered Member + Spouse	$3,000	$6,000
Covered Member + Child(ren)	$3,000	$6,000
Covered Member + Family	$4,500	$9,000

†Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	**Out-of-Network**
Other Plan Benefits	**Plan Pays**	
Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	
Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
Home Health Care	120 visits (combined in-network and out-of-network)	
Hospice Care	180 days (combined in-network and out-of-network)	
Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)
Physician Services (Including General Nursing Care)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	80% (after in-network deductible)
Second Surgical Opinions	100% (after $40 co-pay per office visit)($35 co-pay if opinion is provided by primary care physician)	60% (after deductible)
Professional Services (Outpatient)	100%, (after $40 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Emergency Care Services		
Accident (True Emergencies)	100% (after $150 co-pay)	100% (after $150 co-pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no co-pay)	100% (no co-pay)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $35 co-pay)	80% (after deductible)
Ambulance	80% (after in-network deductible)	80% (after in-network deductible)
Rehab Services		
Inpatient Therapy	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services		
Inpatient	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)
Allergy Testing	100% (after $40 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	**Out-of-Network**
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $40 co-pay for first office visit)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility*	80% (after deductible)	60% (after deductible)
Sterilization Services† (Precertification required for inpatient procedures)	80% (after deductible)	60% (after deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no co-pay or deductible)	60% (after deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after deductible)	60% (after deductible

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

†Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person deductible requirement (currently $500 for in-network and $1,000 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" deductible requirement.

However, once the "family" deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $1,000 for covered member + spouse or for covered member + child(ren), or $1,500 for covered member + family), additional covered persons within the family do not need to satisfy any deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $500 in-network deductible requirement in a given year, none of your other children will be subject to the in-network deductible requirement for that year. On the other hand, if you choose the covered member + family category of coverage and you and your spouse each incur $1,000 of charges that are subject to the in-network deductible requirement, one of your children who is a covered person must satisfy the $500 in-network deductible requirement before the "family" deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family deductible for such calendar plan year (that is, charges incurred before the deductible is satisfied) apply also toward the deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, co-insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual deductible

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$3,000	$6,000	$5,000	$10,000

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)	You pay 20% and the plan pays 80% (after deductible)	You pay 40% and the plan pays 60% (after deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)	You pay 20% and the Plan pays 80% (after deductible)	You pay 40% and the Plan pays 60% (after deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at 1-888-640-3320 for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Skilled Nursing Facility	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Physician Services Including General Nursing Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Pre-admission Testing	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Services				
Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Second Surgical Opinions	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Professional Services (outpatient)	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Urgent Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Ambulance	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Rehab Services				
Inpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient Therapy	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Outpatient	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Maternity and Other Reproductive Services				
Pre-natal Office Visits	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Hospital Maternity Care	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Services to Diagnose Infertility	80% (after deductible)*	60% (after deductible)*	80% (after deductible)*	60% (after deductible)*

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Preventive Health Services				
Recommended Preventive Health Services	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Additional Preventive Health Services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after deductible)	80% (after deductible)	80% (after deductible)	80% (after deductible)
Other covered services	80% (after deductible)	60% (after deductible)	80% (after deductible)	60% (after deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your spouse incurs $3,500 of charges in a year that are subject to the in-network deductible, no other family members will be subject to an in-network deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website at anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

(1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

(2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

(4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain prescription drug

purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount. *For services covered under an HMO plan, please refer to the HMO SPD.*

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 28.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and
  - Prescribed medications (Outpatient prescription drug services are covered

under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).

- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the co-pay or deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam

and one hearing aid per ear during a two calendar-year period; and

- Diabetes management services, including:
  - Educational services;
  - Eye exams; and
  - Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor

performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;

- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no deductible, co-insurance or co-payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no deductible, co-payments or co-insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to deductibles and co-insurance under the PPO option, but are covered by the Plan with no deductible, co-payments or co-insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no deductible, co-payments or co-insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to deductibles and co-insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no deductible, co-payment or co-insurance, when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

- Diphtheria, Tetanus, Pertussis;
- Haemophilus influenza type b;
- Hepatitis A;
- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information:
https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

See the following website for additional information:
https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;
  - Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);

- Screening for gestational diabetes;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for sexually transmitted infections;
- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a co-payment and/or deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a co-payment, co-insurance and/or deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a co-payment, co-insurance and/or deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);

- Inpatient pediatrician visits; and
- Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Employee-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the website **mysourceforhr.com** and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, your next opportunity to enroll the child will not be until the next annual enrollment period or until you experience another qualified life event that permits you to enroll the child.

The Plan pays also benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations for the participant and his or her spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;

  - Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy; and
  - Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

  - Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.
  - Inpatient covered hospital services related to the transplant procedure.
  - Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses

incurred as the result of a transplant provided the recipient is covered under the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Medical Plan

The medical expenses **not** covered under the Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;

- Services for custodial care;
- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The PPO coverage option utilizes a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name

drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a co-pay requirement. If your share of the drug's cost is less than the "minimum co-pay," you pay the minimum co-pay amount. If your share of the drug's cost is greater than the "maximum co-pay," you pay up to the maximum co-pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail co-pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

DRUG CATEGORY	RETAIL PHARMACY (30-Day Supply)		MAIL ORDER (90-Day Supply)		NINETY-DAY SUPPLY AT RETAIL
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$20 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$60 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$120 co-pay	100% after co-pay	20% for the cost of drug subject to minimum co-pay of $60 and maximum co-pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $8,700 per family per calendar year		
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		

* You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the deductible and co-insurance. These expenses are not subject to separate co-insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your deductible, you will pay the discounted cost of the drug. If you have satisfied your deductible, you will pay the applicable co-insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website at **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or co-insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

[Material continued on next page]

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts	20% (after deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after deductible is met)	60% for providers not offering Anthem discounts	40% (after deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

Please Note: Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no co-pays or deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular co-pay, in the case of the PPO Option, or the applicable deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

For medications covered under an HMO option, please refer to the HMO SPD for further information.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan. *For medications not covered under an HMO option, please refer to the HMO SPD for further information.*

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical Plan SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Medical SPD for further details of the Plan coverage.

If you have coverage through an HMO carrier, the HMO carrier provides its own coverage. Please refer to the HMO SPD for further information.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	80% (after deductible)	60% (after deductible)
• Mental Health Outpatient	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $35 co-pay)	60% (after deductible)
• Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $35 co-pay)	60% (after deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after deductible)	Out-of-Network* Plan Pays (after deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

Please see the *"Health Savings Account"* subsection of the **Flexible Benefits Plan** section of the Handbook for information concerning establishing and contributing to a health savings account when you enroll in an HDPPO.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)"* information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;

  - Name and Social Security number of Employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

[Material continued on next page]

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time. Benefits under any HMO Option are underwritten by the insurer. See the SPD furnished by the insurer of an HMO Option for general information concerning such Option.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. See the SPD furnished by the insurer and claims administrator of an HMO Option for information concerning the administration of such Option. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Dental Plan

Preventive Dental

Dental Plan

Dental Plus

Your Dental Plan Options

This is the SPD (the "Dental Plan SPD") for the NiSource Dental Plan, also referred to as the Dental Plan. In this Dental Plan, SPD, the Dental Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Dental Plan to eligible employees and their dependents with the following dental coverage options:

- Preventive Dental;
- Dental Plan; and
- Dental Plus;

Both Dental Plan and Dental Plus provide coverage for eligible dental services such as preventive care services, basic services, and major services. The Dental Plus coverage option is an employee contributory option that also provides for orthodontia benefits.

The Preventive Dental coverage option provides preventive care at 100% of applicable charges and covers fillings and routine extractions at 50% of applicable charges after the deductible. Orthodontia is not covered and there is a deductible required. See "*Highlights of the Dental Plan Coverage*" for further details.

All dental coverage options use a network of providers. When you use an in-network provider you receive the added benefit of lower, negotiated fees. In addition, you are not responsible for fees over the negotiated rate. If you use an out-of-network provider, the amount of the claim that is paid is the product of the applicable coinsurance percentage (set forth below) multiplied by the "Maximum Reimbursable Charge," after the application of any deductible. You are responsible to pay any amount your dentist charges that exceeds the applicable percentage of the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. If you have a question about the determination of the Maximum Reimbursable Charge, contact the Claims Administrator.

To find a provider in your area, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source automated telephone system at **1-888-640-3320**. Customer service associates can then connect you with a provider directly so that you can locate a participating dentist near you.

Eligibility

For information regarding eligibility under the Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320.**

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of the Dental Coverage

Here is a summary of the benefits under each option.

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)		DENTAL PLAN (In or Out-of-Network)		DENTAL PLUS (In or Out-of-Network)	
Annual Deductible	**You Pay**		**You Pay**		**You Pay**	
Covered Member	$75		$50		None	
Covered Member + Spouse	$150		$100		None	
Covered Member + Child(ren)	$75 per covered member up to $225		$50 per covered member up to $150		None	
Covered Member +Family	$75 per covered member up to $225		$50 per covered member up to $150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
Preventive and Diagnostic Treatment	N/A	100%	N/A	100%	N/A	100%
Basic Treatment	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Major Treatment (other than oral surgery or anesthesia)	100%	N/A	50% (after deductible)	50% (after deductible)	50%	50%
Major Treatment (oral surgery or anesthesia only)	50% (after deductible)	50% (after deductible)	20% (after deductible)	80% (after deductible)	20%	80%
Orthodontia (adult and child)	100%	N/A	100%	N/A	50% (up to lifetime maximum) ; 100% thereafter	50% (up to the lifetime maximum)
Maximums	**Plan Pays**		**Plan Pays**		**Plan Pays**	
Annual Maximum	Up to $2,000 per person per year		No annual maximum		Up to $2,000 per person per year	
Annual Maximum - Implants	No Coverage		No annual maximum		Up to $600 per person per year	

FEATURE	PREVENTIVE DENTAL (In or Out-of-Network)	DENTAL PLAN (In or Out-of-Network)	DENTAL PLUS (In or Out-of-Network)
Orthodontia Lifetime Maximum	No Coverage	No Coverage	Up to $1,500 per person

All expenses incurred, whether care is received from a dentist in- or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

For out-of-network providers, after you pay any applicable deductible, the Plan will pay the applicable percentage of Maximum Reimbursable Charges that are covered expenses. In addition to your share of Maximum Reimbursable Charge, you will be required to pay any amount your dentist charges over the Maximum Reimbursable Charge.

Dental Expenses Covered

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

Covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or applicable percentage of the Maximum Reimbursable Charge:

Preventive Treatment (Covered Under All Options)

Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Prophylaxis (cleaning and scaling of teeth);
- Periodontal maintenance procedures (following active therapy) and Periodontal prophylaxis;
- Topical application of fluoride solutions;
- Bite-wing x-rays;

Note: The services described above are each limited to twice in a calendar year.

- Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);
- Panoramic (Panorex) x-ray once in any 3 consecutive calendar years;
- Full-mouth series of x-rays once in any 3 consecutive calendar years; and
- Space maintainers, fixed unilateral – limited to nonorthodontic treatment, up to age 19.

Basic Treatment (Covered Under All Options)

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Routine extractions;
- Amalgam and composite/resin restorations;
- Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);
- Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);
- Periodontal scaling and root planing – entire mouth
- Adjustments – complete denture

  - any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - Removal of impacted tooth, soft tissue
  - Removal of impacted tooth, partially bony
  - Removal of impacted tooth, completely bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

Major Treatment (Covered Under the Dental Plan and Dental Plus Options)

The Plan pays for Major Treatment, provided you select the Dental Plan or Dental Plus coverage option. If you elect the Preventive Dental Option, the Plan does not pay benefits for Major Treatment.

Major Treatment is designed to correct dental disease, defect or injury and includes:

- Crowns

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

  - Porcelain fused to high noble metal
  - Full cast, high noble metal
  - Three-fourths cast, metallic
- Removable Appliances
  - Complete (full) dentures, upper or lower
  - Partial dentures
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge pontics - cast high noble metal
  - Bridge pontics - porcelain fused to high noble metal
  - Bridge pontics - resin with high noble metal
  - Retainer crowns - resin with high noble metal
  - Retainer crowns - porcelain fused to high noble metal
  - Retainer crowns - full cast high noble metal
- Prosthesis over implant – a prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Implants - covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired. Implant

coverage has a separate yearly maximum as shown in *Highlights of the Dental Plan Coverage*.

- Treatment of Temporomandibular Joint Dysfunction (TMJ)
  - Office visit – Adjustment to appliance (no more than six (6) adjustments in six (6) consecutive months after seating or placement of appliance)
  - Transcutaneous Electro-neural Stimulation (no more than four (4) treatments in a six (6)-month period)
  - Trigger Point Injection of Local Anesthetic into Muscle Fascia (no more than four (4) treatments in a six (6)-month period)
  - Mandibular Orthopedic Repositioning Appliance (only one appliance per person in any five (5) year period)

Orthodontia Services (Covered Under Dental Plus)

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option and remain covered under such option throughout the course of treatment. If you select the Preventive Dental or Dental Plan coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

Subject to the foregoing, the Plan pays benefits for the following orthodontia services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Highlights of the Dental Plan Coverage*.

Benefit payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each 3-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable covered percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Orthodontia Payment Example: If your orthodontia treatment costs $5,000 and is estimated to take three years from installation of the appliance to complete, and if you have not been reimbursed for any orthodontia treatment in the past, your first installment will be $625 [the product of 25% multiplied by $5,000 (total cost of treatment) multiplied by 50% (covered percentage), which product is less than $1,500 (lifetime maximum)]. Assuming you remain covered under the Plan and complete the three-year treatment, the remaining charge will be paid in quarterly installments of $156.25 [calculated as set forth above] until you reach your lifetime maximum [$875 remaining after initial installment].

Orthodontia Payment Example

Total Treatment	$5,000.00
Initial Installment	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
Remaining Installments	
Remaining Balance	$3,750.00
CIGNA Allowable (Remaining Balance/12 quarters)	312.50
CIGNA Quarterly Payment (50% of Allowable)	156.25*

*Subject to Lifetime Maximum

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Dental Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

The dental expenses **not** covered include, but are not limited to the following:

- Replacement of teeth that are missing when a person first becomes covered under the Plan;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semiprecision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the immediately following paragraph.

In addition to the foregoing, no payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;
- For charges for services provided by the covered person’s parent, spouse, brother, sister, son or daughter;
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- For charges which would not have been made if the person had no insurance;
- To the extent that billed charges exceed the rate of reimbursement as described in the *Highlights of the Dental Plan Coverage,* including any charge in excess of the Maximum Reimbursable Charge;

- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible dental expenses that are not covered by the Dental Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any dental care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Benefits Program Overview** to learn more about the Plan's COB features.

Filing a Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the Benefits Source website mysourceforhr.com.
- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of employee;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the dental expense.
- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

  CIGNA
  P.O. Box 188037
  Chattanooga, TN 37422-8037

Any claims not submitted after 18 months from the date of service generally will not be considered for payment.

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Dental Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Self-Funded. Benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and through other benefit funding vehicles that may be established from time to time.
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or by any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 cigna.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Vision Plan

Vision Plan Option

Basic Vision Option

Your Vision Plan Options

This is the SPD (the "Vision Plan SPD") for the NiSource Vision Plan, also referred to as the Vision Plan. In this Vision Plan SPD, the Vision Plan is sometimes referred to as the Plan.

NiSource Inc. (the "Company") offers the NiSource Vision Plan to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") with Vision Service Plan Insurance Company who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract, on the one hand, and this Vision Plan SPD, on the other hand, the terms of the Group Contract shall prevail. **You should refer to the Group Contract for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this Vision Plan SPD.** *You may obtain a copy of the Group Contract by contacting the Benefits Source at **1-888-640-3320**.*

This Plan is designed to cover certain costs associated with your vision correction. *Please note that any illness or injury to your eyes would be covered under the Medical Plan, subject to any terms, conditions and limitations set forth in the Medical Plan*.

The Plan utilizes a network of VSP Providers referred to as the VSP Choice Network. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP Choice Network Provider or from a non-VSP Provider. However, if you go to a VSP Choice Network Provider, the Plan pays a higher level of benefits. You also have the option to receive benefit coverage from non-VSP Providers. However, your level of benefit payment will be subject to the non-VSP provider schedule as outlined in the "*Highlights of Your Vision Plan Coverage*".

- **VSP Choice Network Provider** – offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, and if applicable, prescription glasses, and contacts). As long as you receive care or eyewear from a VSP Choice Network Provider, you are responsible for the amount in excess of the Plan's allowance, any applicable co-pays, and the cost of any eyewear or service that the Plan does not cover.
- **Non-VSP Providers** – you have the option to receive your services and eyewear outside the VSP Choice Network. If you do, you must pay the Provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a Provider who participates in the VSP Choice Network, log on to the Benefits Source website at mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to request assistance.

Eligibility

For information regarding eligibility under the Vision Plan, please see the *"Eligibility under the Medical, Dental and Vision Plans"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Vision Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Medical, Dental and Vision Plans"*.

Contributions

You and your Employer will contribute to the cost of the Plan in an amount determined on an annual basis. For further questions, please contact the Benefits Source at **1-888-640-3320** or log on to the Benefits Source website at mysourceforhr.com.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision and FSA Plans"*.

Highlights of Your Vision Plan Coverage

Vision Plan Option

The Vision Plan option pays for the following services and materials:

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year for Adults Twice every calendar year for Children	100%	Up to a $45 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $30 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $50 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $65 allowance
Lenticular	Once every calendar year	100%	Up to a $100 allowance
Frame	Once every other calendar years for Adults Once every calendar year for Children	100%, Up to a $200 frame allowance Featured Frames 100%, Up to a $250 frame allowance	Up to a $70 allowance
Contacts			
Visually Necessary	Once every calendar year in place of glasses	100%	Up to a $210 allowance
Elective	Once every calendar year in place of glasses	100% up to a $175 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, you will pay up to a $50 copay for the contact lens exam (fitting and evaluation) after a 15% discount. The contact lens exam is in addition to your WellVision Exam® to ensure proper fit of contacts.

Polycarbonate lenses are covered in full for dependent Children up to the end of the month in which they turn age 26.

Standard Progressive Lenses are covered in full for all members.

KidsCare - the VSP® KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children by providing two WellVision Exams® and one pair of glasses every calendar year.

Basic Vision Option

COVERED SERVICES	Frequency	VSP Choice Network Provider	Non-VSP Provider
WellVision Exam®	Once every calendar year	100%	Up to a $45 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*." However, in the event of any conflict with that section and the Group Contract, the terms of the Group Contract will prevail.

For purposes of this Vision Plan SPD, (i) "Adult" means either you or your Spouse, provided such person is eligible for, and has enrolled in, coverage under the Plan, (ii) "Child" or "Children" refers to a Child, as defined in the *Definitions* section of the **Benefits Program Overview**, provided such Child is eligible for, and enrolled in, coverage under the Plan, and (iii) "Covered Person" or "member" or "covered member" refers to any person who satisfies the eligibility requirements of the Plan and who is enrolled in coverage under the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

For the Vision Plan Option, the services and materials that the Plan covers include, but are not limited to, the following:

- One WellVision Exam® in every calendar year for Adults.
- Two WellVision Exams® in every calendar year for Children.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame for Adults, one pair every other calendar year (up to the frame allowance).
- Frame for Children, one pair every calendar year (up to the frame allowance)
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the contacts only. There is an additional copay up to $50 for the contact lens exam (fitting and evaluation). This exam is in addition to your WellVision Exam® to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of frame and lenses.

Extra Discounts and Savings

When visiting a VSP Choice Network Provider, you may receive the following, provided that some of the discounts/savings listed below may not apply to the Basic Vision Option:

- Average savings of 30% on non-covered lens enhancements, such as scratch resistant and anti-reflective coatings, light reactive, custom or premium progressives, etc.; 20% off additional prescription glasses and sunglasses within 12 months of your last WellVision Exam®;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent Children;
- Standard progressive lenses covered in full for all members; Routine retinal screening discount;
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK, at a discounted fee with an average 15% off the regular price or 5% off the promotional price. Visit the Claims Administrator's website at vsp.com or call **1-800-877-7195** to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Vision Expenses Not Covered

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. In addition, some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. Covered Persons may obtain details regarding service, material and/or frames exclusions from their VSP Choice Network Provider or by calling VSP's Member Services at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects non-covered lens enhancements, the covered member will pay the additional costs for the options. Some non-covered lens enhancements include:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Hi Index Lenses
- Scratch resistant coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Custom and Premium Progressive lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care

For the cost of a non-covered lens enhancement, speak with your VSP Choice Network Provider or call VSP Member Service at (800) 877-7195

Not Covered

There are no benefits for:

- Services and/or materials not specifically included in this Vision Plan SPD as covered Plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).

- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- KidsCare - Services and/or materials provided by someone other than a VSP Network Provider

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care that you receive. You must submit eligible expenses to the Health Care Flexible Spending Account by March 31 following the Plan Year in which you incur the expense.

Coordination of Benefits (COB)

A Covered Person who is covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the Plan, which may reduce or eliminate the Covered Person's out-of-pocket expense. A Covered Person covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding the Covered Person with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coordinating benefits, it must be determined which plan is billed first. The plan that covers the member as an employee is "primary". The plan that covers the member as a dependent is "secondary".

If the Covered Person is a dependent child and is covered under both parents' plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the Covered Person according to each benefit's out-of-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Please Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. The Member is responsible for any remaining expenses.

How to Access the Vision Benefits

Selecting a VSP Choice Network Provider

- Log on to the Benefits Source website at mysourceforhr.com to find the link to VSP's website that houses the most up-to-date list of VSP Choice Network Providers; or call the Benefits Source at **1-888-640-3320** to locate a VSP Choice Network Provider near you. Call the VSP Choice Network Provider to make an appointment. Identify yourself as a VSP member.
- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network provider files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the provider directly for the eligible expenses.

If you select a Non-VSP Provider

If you receive care from a non-VSP provider, you are required to submit a VSP Request for Reimbursement claim form or you can submit the claim online by signing in as a Member to vsp.com. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete all required fields of the VSP Request for Reimbursement claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the Benefits Source website mysourceforhr.com and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bills should include:
  - Name of patient;
  - Doctor's name or office name;
  - Date of service;
  - Each service received and the amount paid;

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Be sure to submit your completed claim to the Claims Administrator within 1 year of the date of your service.

Your claim will be processed upon receipt. The Plan then pays eligible benefits directly to you. Regardless of whether you will receive care from a VSP Choice Network Provider or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via the Benefits Source at **1-888-640-3320**.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dental Plan, Vision Plan and Health Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Vision Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Group Health Plan
Plan Number:	537
Type of Funding:	Fully Insured
Contribution Source:	Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurance Company. Claims are administered by the Claims Administrator listed below under the group insurance contract.
Claims Administrator (VSP Choice Network Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 385018 Birmingham, AL 35238-5018
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The group insurance contract (the "Group Contract") underwritten by Vision Service Plan Insurance Company provides insured benefits under the Plan. Plan benefits are provided under the terms of the Group Contract and a certificate or evidence of coverage (the "Group Insurance Certificate"). In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

Vision Service Plan Insurance Company, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

Flexible Benefits Plan

Flexible Spending Account Plan

Health Savings Account

Your Flexible Benefits Plan Options

NiSource Inc. (the "Company") maintains the NiSource Flexible Benefits Plan (the "Plan"), which provides eligible employees with the option to participate in a Flexible Spending Account Plan (an "FSA Plan") and to contribute to a Health Savings Account (an "HSA"); provided, however, that you may not contribute to a Health Care FSA and an HSA at the same time.

The Claims Administrator for the FSA Plan is Alight Solutions, LLC, dba "Your Spending Account" or "YSA".

Flexible Spending Account

The FSA Plan has two different Flexible Spending Accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the Flexible Spending Accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $2,750 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the Plan limits or excludes. The maximum limit for Health Care FSA may be adjusted periodically for inflation. Please contact the Benefits Source at **1-888-640-3320** to find out the current limit.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year, or $2,500 per year if you are married and file separate federal income tax returns.

You may not claim any other tax benefit (e.g., the federal dependent care tax credit) for the amount of your before-tax salary reductions under the Dependent Care FSA, although your eligible dependent care expenses in excess of that amount may be eligible for the federal dependent care tax credit. The federal dependent care tax credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. For more information about how the dependent care tax credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). For most individuals, participating in the Dependent Care FSA will produce greater federal tax savings than the dependent care tax credit, but there are some for whom the opposite is true. You should consult a tax advisor to determine what course of action would be best in your situation.

Eligibility

For information regarding eligibility under the FSA Plan, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

Highlights of the Flexible Spending Accounts (FSAs)

FSA Features	Eligible Dependents	Eligible Expenses
Health Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $2,750*	The Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or any person who is your dependent for federal income tax purposes (as determined without regard to such person's gross income).	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans, such as deductibles, co-payments and coinsurance amounts. The expense must be considered as one incurred for "medical care," as defined in the Code. *A non-exhaustive list of eligible expenses can be found later in this section.*
Dependent Care Before-Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the Dependent Care Flexible Spending Account, eligible dependents are: • Any one of the following children or dependents of yours who is under the age of 13, for whom you are entitled to a personal tax exemption, who has the same principal place of abode as you for more than half the year, and who has not provided more than half of his or her own support for such year: a son or daughter, step-son or step-daughter, sibling, step-sibling, half-sibling, sibling-in-law, niece, nephew, grandchild, great-grandchild, or a child adopted or placed for adoption, and, in some cases, a foster child; • Your spouse who is physically or mentally incapable of caring for himself or herself, provided the spouse has the same principal place of abode as you for more than half the year. In addition, if services are provided outside the home, the spouse must regularly spend at least eight hours each day in your home.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A non-exhaustive list of eligible expenses can be found later in this section.*

FSA Features	Eligible Dependents	Eligible Expenses
	• Any one of the following persons, regardless of age, who would qualify as your tax dependent for health coverage purposes under Federal law and who is incapable of self-care, provided the dependent has the same principal place of abode as you for more than half the year: a parent, step-parent, parent-in-law, grandparent, son or daughter, step-son or step-daughter, son- or daughter-in-law, sibling, step-sibling, half-sibling, sibling-in-law, aunt or uncle, niece, nephew, grandchild, great-grandchild, a child adopted or placed for adoption, and, in some cases, a foster child. In addition, if services are provided outside the home, the dependent must regularly spend at least eight hours each day in your home.	

*Amount is subject to change on at least an annual basis. Please contact the Benefits Source at **1-888-640-3320** for the current maximum annual contribution amount for the Health Care FSA.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA are those expenses incurred for "medical care" (as defined under the Code and regulations issued thereunder) by you, your spouse or persons who qualify under the Code as your tax dependents for health coverage purposes, to the extent such expenses are not reimbursed from any other source, are not taken as a deduction on the your income tax return and are not otherwise excluded from eligibility under the terms of the Plan.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with respect to the Health Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dental Plan, Vision Plan and Health Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

Eligible health care expenses include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contact lenses and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
  - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
  - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;
  - Services for chromosome or fertility studies;

- Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate (plus tolls and parking) may be used;
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

This list of covered expenses is subject to change. An expense may not be reimbursed if the IRS would not consider the expense to be eligible.

To confirm if an expense is eligible for reimbursement, call YSA via the Benefits Source at ***1-888-640-3320.***

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;
- Health club dues, YMCA dues, steam bath, etc.;

- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;
- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Health Care FSA Claim

If your health care-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You may incur eligible health care expenses until December 31. You then have until March 31 of the following year to submit claims for expenses you incurred between January 1 and December 31 of the previous year.

Reimbursement of Health Care FSA Claims

You may submit a claim for reimbursement under your Health Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Completed forms should be submitted along with the following documentation:

- **The Explanation of Benefits** (EOB): The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.
- **A Co-pay Receipt**: This receipt is from the provider, and may be the only documentation if the co-pay is the only expense.
- **An Itemized Bill or Statement**: This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:
  - Name and address of the service provider;
  - Dates of service (not the billing date or the paid date);
  - Dollar amount charged;
  - Patient's name; and
  - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

Debit Cards

In addition, if the total annual amount that you elect to contribute to the Health Care FSA is $60 or greater, you will be issued a debit card for use with your Health Care FSA. The debit card may be used only for eligible health-related expenses. When you use your debit card, you are automatically certifying that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other plan.

You may use your debit card to obtain reimbursement for certain approved over-the-counter medications and supplies that are used to treat an illness, injury, or disease and that are purchased from registered vendors. However, you may not use your debit card to obtain reimbursement for over-the-counter medications or supplies that require a prescription or a statement of health or medical need.

The FSA Plan will try to automatically verify any claims you submit through your debit card. However, you should retain documents (such as an EOB, receipt, and itemized bill or statement) to support your claim in case the Claims Administrator requests such information. All expenses you incur must be substantiated in accordance with rules established by the IRS.

If you are paid for an excess or ineligible claim through your debit card, or if you fail to provide requested information to the Claims Administrator regarding substantiation of a claim, your debit card privileges may be suspended and the Plan and Claims Administrator reserve the right to recoup the mistaken payment. If you fail to repay such amount to the Plan, such amount may be withheld from your wages, be offset against other eligible Health Care FSA claims you submit, or be reported on your W-2 as taxable income.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook (provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center. If the care is for a dependent age 13 or over, the dependent must regularly spend at least eight hours each day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp); and
- Certain expenses for children not yet in the first grade, for example:
  - Nursery school;
  - Pre-school.

To confirm if an expense is eligible, call YSA via the Benefits Source at **1-888-640-3320**.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits with

respect to the Dependent Care FSA may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. For more information, see the *"Claims Determination and Appeal Process* – Dependent Care FSA*"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 36.

Dependent Care Expenses Not Eligible

The dependent care expenses that are **not** eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) your participation in the Dependent Care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your Health Care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;
- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim a dependent exemption on your tax return;
- Expenses for health care;
- Educational expenses for kindergarten or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
  - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  - You and your spouse are not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Filing a Dependent Care FSA Claim

For Dependent Care FSA reimbursements, only the current balance in your Dependent Care FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder after you contribute more money to your Dependent Care FSA via future paychecks.

You may submit a claim for reimbursement under your Dependent Care FSA via the Benefits Source website mysourceforhr.com.

Alternatively, you may submit a physical claim form, with attachments, to YSA. To request a claim form, call YSA via the Benefits Source toll-free number **1-888-640-3320**.

Submit the completed form along with the following documentation:

- **Provider's Bill or Itemized Receipt**:. The provider must sign this documentation, and

it must itemize the date(s) of service as well as the amount(s) charged. Canceled checks are not considered acceptable documentation.

- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number)**. For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

If the provider completely fills out the 'Provider Certification' section of the reimbursement form, then you need only submit the completed reimbursement form for your reimbursement request.

Submit the completed form and documentation (if required) to (address is also noted on the form):

Your Spending Account (YSA)
P.O. Box 661147
Dallas, Texas 75266-1147

Be sure to retain copies. Reimbursement request information cannot be returned.

FSA Filing Deadlines

You may submit a health care reimbursement claim at any time after you incur an eligible health care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Health Care FSA after March 31 will be forfeited.

You may submit a dependent care reimbursement claim at any time after you incur an eligible dependent care expense (provided you meet the minimum expense requirement). You have until March 31 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pay for the service).

Remember: Funds that remain in the Dependent Care FSA after March 31 will be forfeited.

Claim Determination and Appeal Process – Health Care FSA

For information regarding the Health Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Vision Plan and Health Care FSA."*

Claim Determination and Appeal Process – Dependent Care FSA

For information regarding the Dependent Care FSA's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Dependent Care FSA."*

Continuation of Coverage

For information regarding continuation of coverage under the FSA Plan, including COBRA continuation coverage under the Health Care FSA, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Medical, Dental, Vision and FSA Plans*."

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of

stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Health Savings Account

If you enroll in one of the High Deductible PPO options (HDPPO 1 or HDPPO 2) you may be eligible to contribute to a Health Savings Account (HSA). An HSA is a portable savings account established and maintained outside the Plan that can be used to pay present and future medical and prescription drug expenses. An HSA is not an employer-sponsored employee benefit plan — it is an individual trust or custodial account that you open with a separate HSA trustee/custodian, such as a bank, life insurance company or other financial institution. Your HSA will be subject to the terms of an agreement you enter into with the HSA trustee/custodian. Such agreement may impose fees and restrictions upon how you use your HSA. The Plan merely allows you to contribute to your HSA in an amount up to the IRS statutory limit. Unlike a Health Care FSA, the HSA account balance can roll over from year to year until withdrawn and earnings accumulate tax-free.

The Health Savings Account is administered by Alight. Your Employer has no authority or control over the funds deposited in your HSA. As a result, the HSA is not subject to ERISA.

You can use the dollars in your HSA to pay the deductible and coinsurance required under the HDPPOs, along with other qualified medical expenses not covered by the plans. Qualified medical expenses are expenses you pay for medical care (as defined in Section 213(d) of the Code) for you, your spouse or dependents (as defined in Section 223 of the Code), to the extent such expenses are not reimbursed by insurance or otherwise.

Funds in the HSA remain in the account until you apply for reimbursement. If you are enrolled in the HDPPO 1 or HDPPO 2, your Employer may make an annual contribution into your HSA on your behalf. However, you must establish or activate your HSA before the end of the Plan Year in order to receive any Employer contributions. If you fail to do so, you will forfeit any Employer contributions for that Plan Year.

The amount you can contribute to your HSA is governed by federal law. Please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Flexible Benefits Plan – HSAs"* for a discussion of limitations upon the amount you may contribute to an HSA. Please call the Benefits Source at **1-888-640-3320** for more information.

Three Ways to Use Your Health Savings Account

- Pay for current qualified medical expenses, such as deductibles and coinsurance, or eligible expenses not covered by the HDPPOs.
- Pay for qualified medical expenses in future years, even if you are no longer enrolled in the HDPPOs.
- Once you reach age 65 (or become disabled), you can use any remaining money in your HSA to pay for qualified medical expenses on a tax-free basis, or you can take a distribution for non-qualified medical expenses, subject to income tax but without incurring a penalty .

Please note: *The information above describes the federal tax treatment of an HSA, but the favorable tax treatment described above may be limited or unavailable for state tax purposes. Please consult your tax advisor for more information.*

Eligibility

For information regarding eligibility for an HSA, please see the *"Eligibility under the Flexible Benefits Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in an HSA, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Flexible Benefits Plan"*.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the FSA Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Medical, Dental, Vision, and FSA Plans"*.

HSA Qualified Medical Expenses

In addition to those services covered under the HDPPOs, you can use your HSA to pay for other qualified medical expenses including, but not limited to the following expenses, to the extent they are not reimbursed from any other source:

- Laser eye surgery;
- Weight loss programs;
- Prescribed drugs and medicines used for medical care, including over the counter medications obtained with a prescription;
- Insulin;
- Long-term care premiums;
- COBRA premiums;
- Health care plan premiums while receiving unemployment;
- Over age 65, you can use the HSA funds to pay for Medicare Parts A or B; and
- Many other services defined as expenses for medical care under Section 213(d) of the Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay income tax on the account distribution as well as a 20% penalty. However, if a distribution is made after age 65, after disability, or after death, the distribution will be subject to income tax, but no penalty tax.

If you have a question about what constitutes a qualified medical expense, please consult your tax advisor or Publication 969 that may be found on the IRS website at irs.gov.

How to Open an HSA

After you have enrolled in an HDPPO option and agreed to the terms and conditions of the HSA custodial agreement, YSA will send you a packet containing basic information on how to use a Health Savings Account.

Paying for Covered Expenses Using the Health Savings Account

The Health Savings Accounts are administered by YSA. When you visit a network provider, you typically do not pay at the time of service. Simply show your Anthem ID card and the following steps will be followed:

1. The claim will be sent to Anthem for processing.
2. You will receive an Explanation of Benefits (EOB) statement showing what was paid under the Plan.
3. Your provider will receive the same statement and bill you for the balance not covered under the Plan.
4. You can then either pay the balance with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

Paying for prescription drugs works differently. The following steps will be followed:

1. You must show the pharmacist your Anthem ID card (the same one you use for medical services).
2. When you pick up your prescription, you can either pay with your HSA debit card (if accepted by your provider) or pay out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

A similar procedure applies for mail-order prescription drug service.

Paying a Provider Who Does Not Participate in the Network

If you visit a provider who is not in the Network, you must either pay the provider at the time of service with your HSA debit card (if accepted by your provider) or pay the provider out of pocket and reimburse yourself afterward by withdrawing funds from your HSA to your personal checking or savings account.

To enroll or to find out more information about the Health Savings Account, please visit the Benefits Source website mysourceforhr.com or call the Benefits Source at **1-888-640-3320** to speak with a representative.

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	NiSource Flexible Benefits Plan (a component of the NiSource Welfare Benefits Program)
Plan Type:	Code Section 125 Plan containing group health plan and non-group health plan components and providing for Pre-Tax Payment of Medical Expenses (Health Plan), Pre-Tax Payment of Dependent Care Expenses and Pre-Tax Contributions to Health Savings Accounts
Plan Number:	537
Type of Funding:	Not applicable
Contribution Source:	Employee. In addition, subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute the entire cost of the Benefit Plan coverage they select. Provided, however, that subject to the terms and conditions of the Plan, the Employer may make contributions to HSAs of employees enrolled in HDPPO 1 or HDPPO 2.
Type of Administration:	Claims are administered by the Claims Administrator listed below under a contract between the Benefit Plan and the Claims Administrator. Distributions from HSAs are not administered through the Plan. Questions concerning investments, distributions or other matters pertaining to an HSA should be directed to Alight, who administers the HSAs. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator for Flexible Spending Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com

Claims Administrator for Health Savings Accounts:	Alight Solutions, LLC, dba Your Spending Account (or YSA) PO Box 661147 Dallas, Texas 75266-1147 mysourceforhr.com
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

Life and AD&D Plan

Employee Term Life Coverage -Basic Plan

Employee AD&D Coverage - Basic Plan

Your Life Insurance and AD&D Options

This is the SPD (the "Life and AD&D SPD") for the NiSource Life Insurance Plan, also referred to as the Life and AD&D Plan. In this Life and AD&D SPD, the Life and AD&D Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan to eligible employees with the following coverage options (each a "Life and AD&D Coverage Option"):

- Basic Employee Term Life Coverage Option;
- Basic Employee Accidental Death and Dismemberment ("AD&D") Coverage Option;

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this summary plan description, on the other hand, the terms of the Group Contract and the Group Insurance Certificate shall prevail. **You should refer to the Group Insurance Certificate for a detailed explanation of the benefits offered under the Plan and the limitations upon those benefits, and for an explanation of the various terms and concepts used in this summary plan description.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

The Plan provides life insurance and AD&D coverage on the persons of eligible employees ("Employee Insurance"). See the individual Benefit Plan sections below for a summary of the benefits offered under each of the Coverage Options listed above.

Eligibility

For information regarding eligibility under the Life and AD&D Plan, please see the *"Eligibility under the Life and AD&D Plan"* subsection of the **Benefits Program Overview**.

Enrollment

For information regarding enrollment in the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Life and AD&D Plan"*.

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option or the Basic Employee AD&D Coverage Option.

When Coverage Begins and Ends

For information regarding when your coverage begins and ends under the Life and AD&D Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Life and AD&D Plan"*.

Definition of "Earnings"

For commission paid employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings include the annualized average commissions earned during the shorter of (i) the 24 month period just prior to your date of loss; or (ii) your period of employment. Bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer are not included.

For all other employees, "Earnings" include your total base income before taxes. Earnings are determined prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. Earnings do not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under each Life and AD&D Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at **1-888-640-3320**.

Insurance under a Life and AD&D Coverage Option may not be assigned.

Basic Employee Term Life Coverage

The Basic Employee Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in the amount of $20,000.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 39.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Employee Term Life Coverage Option (the "Employee Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Employee Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor. The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000.

If you elect to accelerate the full amount of your death benefit, your Employee Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your

Employee Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Payment of Death Benefits under Life Coverage

If you die while covered under the Plan, the amount of insurance on you is payable when Securian's home office receives written proof satisfactory to it that you died while covered under the Plan and insured under the Group Insurance Certificate. If you die within 31 days after ceasing to be covered under the Plan, but while you are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Employee Term Life Insurance are payable according to Securian's beneficiary and mode of settlement rules.

Conversion Privilege for Life Coverage

If all or a part of your Employee Term Life Insurance terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features*" below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

AD&D Coverage

Basic Employee AD&D Coverage Option

The Basic Employee AD&D Coverage Option provides a benefit in the amount of $20.000.

Additional AD&D Coverage

The Plan provides additional benefits under the Basic AD&D Coverage Option for your loss

of life as a result of a covered accident in an automobile while using a seat belt and as a result of an accident in an automobile while using an air bag. The additional benefit is in an amount equal to the lesser of (1) 10% of your full amount of insurance, and (2) $10,000. The additional benefits are subject to various conditions and limitations. For a description of these conditions and limitations, refer to the Group Insurance Certificate.

Covered Losses under AD&D Coverage

AD&D Coverage pays benefits for death or dismemberment resulting, directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen.

The injury must occur while your coverage under the Plan and the Group Insurance Certificate is in force. Your death or dismemberment must occur within 365 days after the date of the injury and while your coverage under the Plan and the Group Insurance Certificate is in force.

The amount of the accidental death and dismemberment benefit is described below:

Loss of or by reason of	Percent of Person's Amount of Insurance
Life; both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; speech and hearing; quadriplegia	100%
Paraplegia	75%
One hand; one foot; sight of one eye; speech; hearing; hemiplegia	50%
Thumb and index finger of one hand	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs and both lower limbs.

Paraplegia means total and permanent paralysis of both lower limbs. Hemiplegia means total and permanent paralysis of both the upper limb and lower limb on one side of the body.

Benefits may be paid for more than one accidental injury but the total amount of insurance payable under the Plan and the Group Insurance Certificate for all of your losses due to any one accident will never exceed the full amount of insurance described above.

Benefits will be paid upon receipt by Securian at its home office of written proof satisfactory to it that you or your eligible dependent died or suffered dismemberment as a result of an accidental injury.

Losses Not Covered

A Loss is not covered if it results from any of the following: (1) Suicide or attempted suicide, while sane or insane; (2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries; (3) sickness, whether the loss results directly or indirectly from the sickness; (4) medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment; (5) Any infection (but this does not include (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance); (6) War, or any act of war ("War" means declared or undeclared war and includes resistance to armed aggression); (7) an accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including Reserve or National Guard active duty for training); (8) travel in or descent from any aircraft, except: a) as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; b) while the employee is performing as a pilot or crew

member of an employer owned, leased or operated aircraft; or c) while the employee is riding as a passenger in an aircraft which is owned, leased, or operated by the eligible employee's employer or its affiliate or by a customer of the employer or its affiliate; (9) commission of or attempt to commit an assault or felony; (10) being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor; or (11) participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required. For more information, see the *"Claims Determination and Appeal Process –Life and AD&D Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 39.

Portability of Life and AD&D Coverage

If coverage under any of the Life and AD&D Coverage Options ceases, you may have the right to apply for coverage for yourself and for your "eligible dependent," as the case may be, under a Portability Plan maintained by Securian. The terms and conditions (including the amount of coverage) under the Portability Plan will not be the same as those under the Plan.

To continue coverage under the Portability Plan, you must make a written request and make the first premium contribution within 31 days after insurance provided by the Plan or Group Policy would otherwise terminate. Evidence of insurability will not be required. Portability coverage then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be your portability date and you are then considered to have portability status. In order for your eligible dependents to continue dependent coverage under a Life and AD&D Coverage Option, you must port your corresponding employee coverage. In addition, life insurance coverage must be ported in order to port accidental death and dismemberment insurance.

See the table below entitled *"Highlights of Conversion and Portability Features,"* for additional details regarding the portability feature. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Portability Coverage in Lieu of Conversion Coverage

The right to elect term life coverage under the Portability Plan is in lieu of the conversion privilege under the Employee Term Life Insurance, except that you may convert the amount of insurance under the Employee Term Life Insurance that exceeds the maximum amount of coverage that may be obtained under the Portability Plan.

Your Eligibility for Portability Coverage

You are eligible to continue your Employee Insurance under the terms of the Plan and Group Insurance Certificate if you no longer meet the eligibility requirements for coverage (other than portability coverage) due to any of the following:

(1) you terminate employment, including retirement; or

(2) you are no longer in a class eligible for coverage or you are on a leave or layoff; or

(3) a class or group of employees insured under the Plan is no longer considered eligible and there is no successor plan for that class or group. (Successor plan means an insurance policy or policies provided by Securian or another insurer that replaces insurance provided under the Plan).

You will not be eligible to request portability coverage if you:

(1) have attained the age of 80; or

(2) with respect to Term Life Coverage, have converted your insurance to an individual life policy as permitted by any conversion rights under the Plan; or

(3) were not actively at work due to sickness or injury on the date immediately preceding your portability date; or

(4) lose eligibility due to termination of the Plan or Group Policy.

Maximum and Minimum Amount of Coverage under the Portability Plan

The maximum amount of insurance that can be continued under the Portability Plan is the amount of insurance that was in force on the insured's portability date. However, for an insured age 65 or older on his or her portability date, the amount will not be more than 65% of the amount in force on the insured's portability date.

When an insured attains age 65, the amount of insurance on his or her life continued under the Portability Plan will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 80.

The minimum amount of insurance that can be continued under the Portability Plan is $10,000.

You may elect to reduce the amount of insurance on your life under the Portability Plan. However, your remaining amount of insurance must be at least $10,000. The amount of insurance continued under the Portability Plan will never increase.

Conversion of Portability Coverage

At any time after insurance has been continued under the Portability Plan, it may be converted to a policy of individual insurance with Securian. All other conditions and provisions applicable to conversion coverage will apply. See the Group Insurance Certificate for additional details.

Regaining Eligibility Under Plan

If you are continuing coverage under the terms of Portability Plan, and you again meet the eligibility requirements of the Plan and the Group Insurance Certificate (not including the requirements for portability coverage), you shall no longer be considered to have portability status. Insurance may be continued only under the terms of the Plan and the Group Insurance Certificate, unless and until you no longer meet the eligibility requirements thereunder and again return to portability status as provided for herein.

Termination of Portability Coverage

Insurance being continued under the Portability Plan will terminate on the earliest of the following:

(1) the insured attaining age 80; or

(2) the date the insured again meets the eligibility requirements of the Plan and the Group Insurance Certificate; or

(3) 31 days after the due date of any premium contribution which is not made.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Coverage can be converted or ported to:	Individual Life Policy	Participation in Portability Plan
Evidence of Insurability Required	No.	No.
Application Deadline	Application and first month premium due 31 days after your coverage termination.	For life coverage, application due 31 days after your coverage termination. Securian will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101

Conformity with State Law

If any provision of this summary plan description or of the Group Insurance Certificates or Group Contracts is in conflict with the laws of the state governing the Group Contracts or Group Insurance Certificates, the provision will be deemed to be amended to conform to such laws.

Filing A Claim

If you have a claim, you should obtain a claim form and follow the instructions on the form. For AD&D claims, Securian must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Life and AD&D Coverage Option provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end. A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at ***1-888-640-3320****, or online via the Benefits Source website at* mysourceforhr.com*. If you do not receive the form from Securian within 15 days of your request, send Securian written* proof of claim without waiting for the form.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process –Life and AD&D Plan."*

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Life Insurance Plan (a component of NiSource Life and Medical Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance and accidental death and dismemberment benefits
Plan Number:	536
Contribution Source:	Basic Employee Insurance: Employer Optional Employee and Dependents Insurance: Employee and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410

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

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this summary plan description and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Exempt Full-Time Employees Hired or Rehired On or After January 1, 2010