COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

26. Provide copies of credit rating agency reports, e.g., Standard and Poor's, Moody's, and Fitch, for NiSource from 2013 through the present date.

Response:

Attached are the following NiSource Inc. rating agency reports for the period January 1, 2013 through present time.

- Attachment A - Standard & Poors (February 2013)
- Attachment B - Fitch (May 2013)
- Attachment C - Moody's (November 2013)
- Attachment D - Fitch (December 2013)
- Attachment E – Moody's (January 2014)
- Attachment F– Standard & Poors (March 2014)
- Attachment G – Fitch (April 2014)
- Attachment H – Moody's (September 2014)
- Attachment I – Fitch (September 2014)
- Attachment J – Standard & Poors (September 2014)
- Attachment K – Moody's (October 2014)
- Attachment L – Standard & Poors (March 2015)

- Attachment M– Moody's (May 2015)
- Attachment N – Moody's (June 2015)
- Attachment O –Standard & Poors (June 2015)
- Attachment P – Moody's (June 2015)
- Attachment Q – Fitch (June 2015)
- Attachments R – Fitch (October 2015)
- Attachment S – Moody's (June 2016)
- Attachment T – Fitch (June 2016)

STANDARD
& POOR'S
RATINGS SERVICES

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NiSource Inc.

Primary Credit Analyst:
Gerrit W Jepsen, CFA, New York (1) 212-438-2529; gerrit_jepsen@standardandpoors.com

Secondary Contact:
Michael T Ferguson, CFA, CPA, New York (1) 212-438-1000;
michael_ferguson@standardandpoors.com

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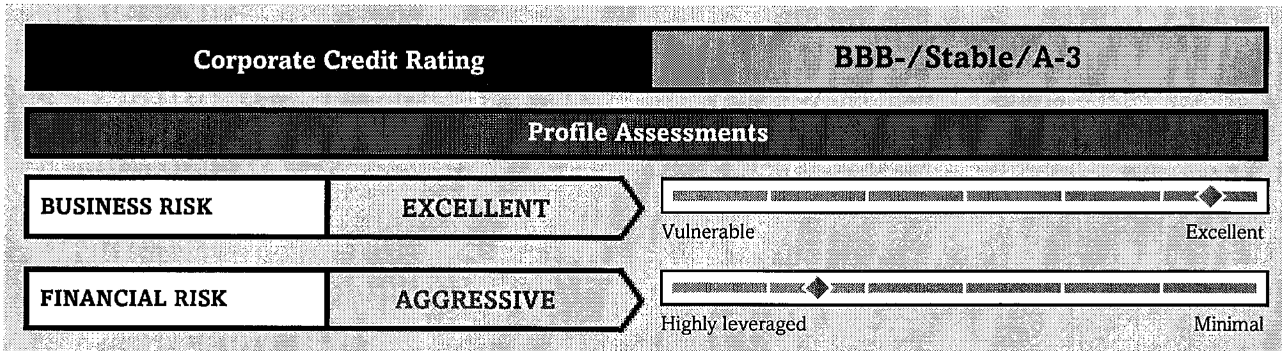

Rationale

Business Risk: Excellent

- Conservative business strategy that focuses almost exclusively on regulated businesses
- Regulated utilities with mostly low operating risks
- Lack of competition in regulated service territories
- Diverse service area in seven states and numerous regulatory jurisdictions
- Large residential customer base
- Gas distribution operations with geographic diversity and integration with the company's gas transmission network, providing operational flexibility
- Electric utility subsidiary Northern Indiana Public Service Co.'s higher-than-average dependence on industrial customers and flat growth at the utility

Financial Risk: Aggressive

- Relatively high debt leverage (debt to EBITDA of more than 5x) that we expect to remain at this level or higher
- Subsidiary Northern Indiana Public Service Co.'s high cost structure and heavy dependence on the industrial sector
- High capital spending
- Continuing high dividends
- Negative discretionary cash flow that could grow with greater capital spending

Outlook: Stable

The stable outlook reflects our expectation of steady operating and financial performance at the regulated subsidiaries and annual capital spending of more than $1.5 billion. Our base forecast includes FFO to debt of about 12%, debt to EBITDA of about 5.5x, and debt leverage to total capital of less than 63%, consistent with our expectations for the rating.

Downside scenario

We could lower ratings if financial measures weaken and remain at less-supportive levels, including a FFO to debt ratio of less than 10%.

Upside scenario

While we do not currently contemplate an upgrade, credit quality could improve if cash flow measures considerably improve, specifically FFO to debt of more than 15% on a sustained basis. In addition, we would expect debt to EBITDA of less than 5x and debt leverage of less than 60%. The company can accomplish this by paying down debt with higher internally generated cash flow, increased equity issuances, or asset dispositions.

Standard & Poor's Base-Case Scenario

Our base case scenario results in moderate EBITDA growth, growing capital spending, and rising debt leverage.

Assumptions

- Low single-digit base (excludes rate rider recovery) growth in EBITDA for the next three years
- Rate recovery through various surcharge mechanisms is authorized by regulatory commissions
- High dividend and capital spending that results in negative discretionary cash flow, resulting in external funding requirements
- Annual capital spending forecasted to be $1.5 billion to $1.8 billion over next three years

Key Metrics

	LTM 9/30/2012	2013E	2014E
FFO/Total debt	18.9%	12%-13%	11%-12%
Debt/EBITDA	5.3x	5.3x-5.7x	5.3x-5.7x
Total debt/Total capital	61.2%	62%-66%	63%-67%

*Standard & Poor's adjusted consolidated financial ratios for NiSource include adjustments for operating leases ($140 mil. of debt), pension-related items ($604 mil.), accrued interest not included in reported debt ($112 mil.), and asset retirement obligations ($95 mil.). EBITDA adjustments include pension-related items ($28 mil.), share-based compensation expense ($39 mil.), and income of unconsolidated companies ($28 mil.). FFO adjustments include pension-related items ($283 mil.). A--Actual. E--Estimate.

Company Description

NiSource Inc. is an energy hold company that is one of the largest natural gas distribution companies in the U.S., with nine gas distribution subsidiaries serving roughly 3.3 million customers in seven states extending from Indiana to Massachusetts. NiSource owns and operates 15,000 miles of interstate pipelines, and its natural gas storage operations can hold up to 640 billion cubic feet (bcf) of natural gas. Subsidiary Northern Indiana Public Service Co. (NIPSCO) provides electricity to 457,000 customers in northern Indiana. NiSource Finance Corp. is the financing entity for NiSource Inc., which is the guarantor of all the debt.

Business Risk: Excellent

Mostly regulated natural gas and electric operations

NiSource consist of low-risk regulated utilities and natural gas pipelines and will generate more than 80% of its operating cash flow through regulated operations. We consider the company's gas distribution operations to be above average, characterized by ample geographic diversity and integration with the company's gas transmission network, which provide operational flexibility. Nearly all of the gas distribution subsidiaries' needs are contracted with Columbia Transmission, with roughly 70% of peak gas needs met with storage gas. This bolsters service reliability, thereby supporting the business risk profile. Cash flow variability is also low given material revenue stabilization and cost-tracking mechanisms. The gas transmission network has a huge underground storage system (working gas of about 280 billion cubic feet) and access to multiple supply basins. Slightly more than 90% of revenues are derived from firm take-or-pay contracts, and a moderate contract life exists mainly at maximum rates. These contracts provide more cash flow certainty because gas shippers pay whether or not they have gas to be transported.

NIPSCO mostly burns coal (nearly 80% of capacity), so it incurs higher-than-average environmental costs, but there is timely cost recovery through an environmental rate surcharge. NIPSCO's customer growth is flat, service territory unemployment is slightly higher than the national average, and it has significant industrial customer exposure representing about one-half of its total volumes. The industrial customers are susceptible to a weak economy, but volumes are back to typical levels following a falloff in recent years due to a weak economy. NIPSCO's residential rates are higher than the Indiana state average, but not the highest and are lower than the national average.

Reflected in the business risk profile is our assessment of the company's management and governance as "satisfactory". Management will execute its strategy to expand its midstream operations in a credit supportive manner that helps maintain a business risk profile assessment. There will be effective management of regulatory relationships.

S&P Base-Case Operating Scenario

- The economic conditions in the company's service territories are either holding steady or improving, which will likely increase customer usage.
- Base EBITDA is forecasted to grow from customer growth, volume-related growth, and expansion projects that are expected to come into service over the forecasted period.
- Utility subsidiaries operate under regulatory terms that largely support credit quality and are generally constructive, which includes good gas adjustment and other cost-pass-through mechanisms. These provide for timely recovery of costs that helps support steady revenues.
- NIPSCO continues spending on new transmission projects and pollution-control equipment while seeking higher operating cash flow through various rate surcharges and base rates. Once rate recovery of these investments begins, we forecast that revenue and EBITDA will grow beyond base levels.
- For the gas-gathering business, the largest source of new growth projects will likely be in the Marcellus Shale gas-gathering region, with spending backed by long-term off-take contracts, boosting EBITDA growth.
- Over the next five years, the company expects to spend $1.5 billion to modernize Columbia Transmission. An additive capital demand charge will help support cost recovery.

Peer comparison

Table 1

NiSource Inc.--Peer Comparison

Industry sector: combo

	NiSource Inc.	**CenterPoint Energy Inc.**	**Sempra Energy**	**Vectren Corp.**	**AGL Resources Inc.**
Rating as of Feb. 25, 2013	BBB-/Stable/A-3	BBB+/Stable/A-2	BBB+/Stable/A-2	A-/Stable/--	BBB+/Stable/A-2
	--Average of past three fiscal years--				
(Mil. $)					
Revenues	6,363.5	8,128.7	9,048.3	2,181.2	2,342.7
EBITDA	1,593.9	1,790.0	3,429.6	555.8	685.8
Operating income	982.5	1,186.0	1,903.0	323.6	505.8
EBIT	996.0	1,235.3	2,275.0	317.1	512.8
Interest Expense	430.2	509.7	656.0	109.2	128.1
Net income from cont. oper.	276.5	528.0	1,071.7	136.1	209.3
Funds from operations (FFO)	1,337.6	1,312.9	2,326.1	466.6	542.8
Working capital	157.7	161.0	(141.0)	(35.7)	17.7
Cash flow from operations	1,495.2	1,473.9	2,185.1	430.9	560.4
Capital expenditures	938.4	1,258.7	2,278.6	343.2	504.0
Free operating cash flow	556.8	215.2	(93.5)	87.6	56.4
Dividends paid	255.6	310.7	391.0	110.9	157.0
Discretionary cash flow	301.3	(95.4)	(484.5)	(23.2)	(100.6)
Cash and short-term investments	12.4	737.3	424.7	10.3	57.3
Debt	8,207.1	7,611.3	12,355.5	1,978.2	3,415.5
Preferred stock	0.0	0.0	152.3	0.0	0.0
Equity	5,013.5	3,353.0	9,655.7	1,445.1	2,331.3
Adjusted ratios					

Table 1

NiSource Inc.--Peer Comparison (cont.)					
EBITDA margin (%)	25.0	22.0	37.9	25.5	29.3
EBITDA interest coverage (x)	3.7	3.5	5.2	5.1	5.4
EBIT interest coverage (x)	2.3	2.4	3.5	2.9	4.0
Return on capital (%)	6.5	9.0	10.1	8.2	8.8
FFO/debt (%)	16.3	17.2	18.8	23.6	15.9
Free operating cash flow/debt (%)	6.8	2.8	(0.8)	4.4	1.7
Debt/EBITDA (x)	5.1	4.3	3.6	3.6	5.0
Total debt/debt plus equity (%)	62.1	69.4	56.1	57.8	59.4

Financial Risk: Aggressive

Large capital expenditures and substantial leverage

We consider NiSource's financial risk profile aggressive, reflecting adjusted financial measures that are in line with the rating. This assessment reflects large capital expenditures, mostly for improvement to gas pipelines and for environmental compliance programs at NIPSCO. Also, we consider the company's financial policies to be aggressive. The elevated capital spending and dividend payments translate to rising negative discretionary cash flow over the forecast period, requiring management to maintain vigilant cost recovery to maintain cash flow measures. The negative discretionary cash flow also points to external funding needs.

S&P Base-Case Cash Flow And Capital Structure Scenario

Our base-case suggests weakening cash flow measures over the next several years, due in part to lower bonus depreciation while growth capital spending is boosted. We expect debt leverage measures to remain roughly the same as previous years, with debt to EBITDA exceeding 5x and total debt to total capital of more than 60%.

- The majority of capital spending will be for utility maintenance and rate-tracked investments, with the remainder on growth projects. The increased capital spending results in weakening internal funding and a greater reliance on capital markets for financing.
- Refinancing of many upcoming debt maturities.
- Cash dividends grow faster than historical levels based on management provided annual growth rate of 3% to 5%.
- Continuing commitment to credit quality and the maintenance of a balanced capital structure.

Financial summary

Table 2

NiSource Inc.--Financial Summary					
Industry sector: combo					
	--Fiscal year ended Dec. 31--				
	2011	**2010**	**2009**	**2008**	**2007**
(Mil. $)					
Revenues	6,019.1	6,422.0	6,649.4	8,874.2	7,939.8

Table 2

NiSource Inc.--Financial Summary (cont.)					
EBITDA	1,564.2	1,638.8	1,578.6	1,499.4	1,517.0
Operating income	986.8	996.6	964.0	910.4	944.0
EBIT	994.1	1,015.4	978.6	940.3	946.9
Net income from continuing operations	303.8	294.6	231.2	369.8	312.0
Funds from operations (FFO)	1,583.7	1,225.1	1,203.9	1,051.6	906.7
Capital expenditures	1,138.3	801.1	875.7	1,283.6	848.1
Free operating cash flow	91.2	301.0	1,278.3	(604.1)	(33.7)
Dividends paid	257.8	255.6	253.3	252.4	252.1
Discretionary cash flow	(166.6)	45.4	1,025.0	(856.5)	(285.8)
Debt	8,477.4	8,070.0	8,073.9	8,613.3	7,281.2
Preferred stock	0.0	0.0	0.0	0.0	0.0
Equity	5,011.5	4,982.8	5,046.1	4,907.5	5,389.3
Debt and equity	13,488.9	13,052.8	13,120.0	13,520.8	12,670.5
Adjusted ratios					
EBITDA margin (%)	26.0	25.5	23.7	16.9	19.1
EBITDA interest coverage (x)	4.0	4.0	3.2	3.4	3.3
EBIT interest coverage (x)	2.6	2.4	2.0	2.1	2.1
FFO interest coverage (x)	5.0	3.9	3.2	3.2	2.9
FFO/debt (%)	18.7	15.2	14.9	12.2	12.5
Discretionary cash flow/debt (%)	(2.0)	0.6	12.7	(9.9)	(3.9)
Net cash flow/capex (%)	116.5	121.0	108.5	62.3	77.2
Debt/EBITDA (x)	5.4	4.9	5.1	5.7	4.8
Debt/debt and equity (%)	62.8	61.8	61.5	63.7	57.5
Return on capital (%)	6.3	6.7	6.5	6.4	6.7
Return on common equity (%)	6.1	6.0	4.7	7.1	5.8
Common dividend payout ratio (unadjusted) (%)	85.0	86.8	109.6	68.3	80.8

Liquidity: Adequate

NiSource liquidity is considered as "adequate" under our liquidity methodology. We expect that NiSource's liquidity sources over the next 12 months will exceed its uses by 1.2x. We do expect NiSource will need to access the capital markets over the next few years to meet its liquidity needs, particularly for debt maturities and capital spending.

In our assessment, NiSource has good relationships with its banks and has a good standing in the credit markets, having successfully issued debt during the recent credit crisis.

Principal Liquidity Sources	Principal Liquidity Uses
• Funds from operations of about $1.2 billion in 2013 • Assumed credit facility availability of about $1.1 billion in 2013 • Working capital and cash of $30 million in 2013	• Debt maturities of about $500 million in 2013 • Maintenance capital spending of roughly $1.1 billion in 2013 • Cash dividends of $300 million in 2013

Debt maturities

Table 3

NiSource Inc.--Debt Maturities

(Mil. $)	2013	2014	2015	2016	2017	2018
	507.2	559.2	495.0	434.4	603.0	800.0

Covenant Analysis

As of Sept. 30, 2012, the company finance entity, NiSource Finance, had an adequate cushion of compliance with its one financial covenant (debt to total capitalization to be less than 70%. Headroom could erode if debt rises rapidly without adequate growth in equity during this capital spending phase.

Compliance Expectations	Schedule Of Step-Downs/Step-Ups
Covenant: 70% maximum debt to capitalization • Company was in compliance as of Sept. 30, 2012 • Single-digit EBITDA growth and higher capital spending should still permit a healthy cushion • Covenant headroom could decrease without adequate cost recovery of capital investments	• Current: 70% • As of year-end 2013: 70% • As of year-end 2014: 70%

Reconciliation

Table 4

Reconciliation Of NiSource Inc. Reported Amounts With Standard & Poor's Adjusted Amounts (Mil. $)

	--Fiscal year ended Dec. 31, 2011--									
NiSource Inc. reported amounts										
	Debt	**Shareholders' equity**	**Revenues**	**EBITDA**	**Operating income**	**Interest expense**	**Cash flow from operations**	**Cash flow from operations**	**Dividends paid**	**Capital expenditures**
Reported	7,953.8	4,997.3	6,019.1	1,460.1	905.1	376.8	920.3	920.3	257.8	1,125.2
Standard & Poor's adjustments										
Operating leases	140.0	--	--	8.3	8.3	8.3	32.1	32.1	--	16.2
Postretirement benefit obligations	604.1	--	--	27.7	27.7	--	282.9	282.9	--	--

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Table 4

Reconciliation Of NiSource Inc. Reported Amounts With Standard & Poor's Adjusted Amounts (Mil. $) (cont.)										
Capitalized interest	--	--	--	--	--	3.1	(3.1)	(3.1)	--	(3.1)
Share-based compensation expense	--	--	--	39.2	--	--	--	--	--	--
Asset retirement obligations	95.2	--	--	0.6	0.6	0.6	(2.7)	(2.7)	--	--
Reclassification of nonoperating income (expenses)	--	--	--	--	(7.3)	--	--	--	--	--
Reclassification of working-capital cash flow changes	--	--	--	--	--	--	--	354.2	--	--
Debt--accrued interest not included in reported debt	111.9	--	--	--	--	--	--	--	--	--
Debt--other	(427.6)	--	--	--	--	--	--	--	--	--
Equity--other	--	14.2	--	--	--	--	--	--	--	--
EBITDA--income (expense) of unconsolidated companies	--	--	--	28.3	28.3	--	--	--	--	--
D&A--impairment charges/(reversals)	--	--	--	--	16.8	--	--	--	--	--
EBIT--income (expense) of unconsolidated companies	--	--	--	--	14.6	--	--	--	--	--
Total adjustments	523.6	14.2	0.0	104.1	89.0	12.0	309.2	663.4	0.0	13.1

Standard & Poor's adjusted amounts

	Debt	Equity	Revenues	EBITDA	EBIT	Interest expense	Cash flow from operations	Funds from operations	Dividends paid	Capital expenditures
Adjusted	8,477.4	5,011.5	6,019.1	1,564.2	994.1	388.8	1,229.5	1,583.7	257.8	1,138.3

Related Criteria And Research

- 2008 Corporate Criteria: Analytical Methodology, April 15, 2008
- Liquidity Descriptors For Global Corporate Issuers, Sept. 28, 2011
- Business Risk/Financial Risk Matrix Expanded, Sept. 18, 2012
- 2008 Corporate Ratings Criteria: Ratios And Adjustments, April 15, 2008
- Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012

Business And Financial Risk Matrix

	Financial Risk					
Business Risk	Minimal	Modest	Intermediate	Significant	Aggressive	Highly Leveraged
Excellent	AAA/AA+	AA	A	A-	BBB	--
Strong	AA	A	A-	BBB	BB	BB-
Satisfactory	A-	BBB+	BBB	BB+	BB-	B+
Fair	--	BBB-	BB+	BB	BB-	B
Weak	--	--	BB	BB-	B+	B-
Vulnerable	--	--	--	B+	B	B- or below

Note: These rating outcomes are shown for guidance purposes only. The ratings indicated in each cell of the matrix are the midpoints of the likely rating possibilities. There can be small positives and negatives that would lead to an outcome of one notch higher or lower than the typical matrix outcome. Moreover, there will be exceptions that go beyond a one-notch divergence. For example, the matrix does not address the lowest rungs of the credit spectrum (i.e., the 'CCC' category and lower). Other rating outcomes that are more than one notch off the matrix may occur for companies that have liquidity that we judge as "less than adequate" or "weak" under our criteria, or companies with "satisfactory" or better business risk profiles that have extreme debt burdens due to leveraged buyouts or other reasons. For government-related entities (GREs), the indicated rating would apply to the standalone credit profile, before giving any credit for potential government support.

Ratings Detail (As Of February 25, 2013)

NiSource Inc.	
Corporate Credit Rating	BBB-/Stable/A-3
Commercial Paper	
Local Currency	A-3
Senior Unsecured	BBB-
Corporate Credit Ratings History	
28-Jul-2011	BBB-/Stable/A-3
05-Mar-2009	BBB-/Stable/NR
16-Dec-2008	BBB-/Negative/NR
Related Entities	
Bay State Gas Co.	
Issuer Credit Rating	BBB-/Stable/NR
Senior Unsecured	BBB-
NiSource Capital Markets Inc.	
Issuer Credit Rating	BBB-/Stable/NR
Senior Unsecured	BBB-
NiSource Finance Corp.	
Issuer Credit Rating	BBB-/Stable/A-3
Northern Indiana Public Service Co.	
Issuer Credit Rating	BBB-/Stable/NR
Senior Unsecured	BBB-
Senior Unsecured	BBB/Developing

*Unless otherwise noted, all ratings in this report are global scale ratings. Standard & Poor's credit ratings on the global scale are comparable across countries. Standard & Poor's credit ratings on a national scale are relative to obligors or obligations within that specific country.

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McGRAW-HILL

FitchRatings

Corporates

Energy (Oil & Gas)/ U.S.

NiSource Inc.

NiSource Finance Corp. and NiSource Capital Markets, Inc.

Full Rating Report

Ratings

NiSource Inc.	
Long-Term IDR	BBB–
NiSource Finance Corp.	
Long-Term IDR	BBB–
Short-Term IDR and CP	F3
Senior Unsecured	BBB–
NiSource Capital Markets, Inc.	
Long-Term IDR	BBB–
Senior Unsecured	BBB–

IDR – Issuer default rating.

Rating Outlooks

NiSource Inc.	Stable
NiSource Finance Corp.	Stable
NiSource Capital Markets, Inc.	Stable

Financial Data

NiSource Inc.

(x)	12/31/12	3/31/13
EBITDA/Interest	4.0	3.8
FFO Coverage	4.3	3.9
Debt/EBITDA	5.0	4.9
FFO/Debt (%)	16.3	15.3

Related Criteria

Corporate Rating Methodology, Aug. 18, 2012

Short-Term Ratings Criteria for Non-Financial Corporates, April 2, 2013

Analysts

Ralph Pellecchia
+1 212 908-0586
ralph.pellecchia@fitchratings.com

Kathleen Connelly
+1 212 908-0290
kathleen.connelly@fitchratings.com

Key Rating Drivers

Low Business Risk: NiSource Inc.'s (NI) rating reflects the low business risk and consistent operating performance generated by its geographically diverse mix of regulated operations. Other considerations include the long-term financial impact of aggressive pipeline and gas utility system modernization programs and electric environmental capital expenditures, with a substantial portion of recoveries expected to be received through tracking mechanisms and relatively weak credit metrics.

Year-end Leverage Remains High: NI's 2012 debt to EBITDA was 5.0x. NI's financial profile is expected to remain consistent with its current rating through its multi-year infrastructure-build cycle. Fitch projects NI's 2013 debt to EBITDA to be approximately 5.0x. Typically NI's leverage peaks at the end of the year as a result of seasonal gas storage purchases at its gas utilities and drops during the following months as gas costs are recovered.

Pipeline System Modernization Provides Stability: In January 2013, the Federal Energy Regulatory Commission (FERC) approved a settlement between NI's Columbia Gas Transmission (Columbia) subsidiary and its customers addressing needed pipeline infrastructure investment. Under the settlement, Columbia will invest approximately $300 million per year on system improvements, in addition to $100 million in ongoing maintenance, over the 2013 through 2017 period. The settlement includes adjustments to rates and a capital cost tracker that provides a recovery of and return on Columbia's investment. On balance, the settlement provides near-term certainty of recovery, albeit modest in the beginning years. It also establishes a regulatory model for future infrastructure investment by Columbia which could reach $4 billion over a 10 – 15 year period.

Rating Outlook Stable: NI's Stable Outlook reflects the scale and diversity of its regulated operations.

Rating Sensitivities

Positive: Future developments that may, individually or collectively, lead to a positive rating action include:

--Reduced regulatory risk with expanded revenue tracking mechanisms;

--Improving credit metrics through some combination of earnings growth and or debt reduction with sustained leverage at 4.5x or below.

Issuer Rating History

Date	LT IDR (FC)	Outlook/ Watch
Dec. 11, 2012	BBB-	Stable
Dec. 13, 2011	BBB-	Stable
Dec. 14, 2010	BBB-	Stable
Dec. 15, 2009	BBB-	Stable
Feb. 4, 2009	BBB-	Stable
May. 14, 2008	BBB	Stable
Jul. 10, 2007	BBB	Stable
Mar. 31, 2006	BBB	Stable
Dec. 6, 2005	BBB	Stable
Sep. 21, 2005	BBB	Stable
Jun. 30, 2003	BBB	Stable
Feb. 6, 2002	BBB	RWN
Dec. 6, 2001	BBB	Stable
Oct. 27, 2000	BBB+	Stable

Negative: Future developments that may individually or collectively, lead to a negative rating action include:

--Unfavorable regulatory decisions;

--Higher than anticipated leverage which could result should NI not issue adequate equity to help fund its significant capital program;

--Debt to EBITDA above 5.5x on a sustained basis would be a catalyst for a negative rating action.

Financial Overview

Liquidity and Debt Structure

NI's liquidity is expected to be adequate. NI affiliate, NiSource Finance Corp. (NiSource Finance), has a $1.5 billion revolving credit facility that matures in May 2017. The company also issues 'F3' rated commercial paper under a $1.5 billion CP program that is backstopped by the revolver. The revolver has one financial covenant which sets a maximum consolidated debt-to-cap ratio of 70%. The revolver also includes limitations on liens and restrictions on asset sales. At March 31, 2013, NI had approximately $ 795 million in net available liquidity under the revolver. NI also has a total of $515 million of accounts receivable securitization facilities as follows: $240 million at Columbia Gas of Ohio; $200 million at Northern Indiana Public Service Co.; and $75 million at Columbia Gas of Pennsylvania.

On April 15, 2013, NI Finance increased the size of a three-year term loan to $325 million from $250 million and extended its maturity one year to April 2016. On March 1, 2013, NI Finance redeemed $420 million of 6.15% unsecured notes and on April 12, 2013, it issued $750 million of 4.80% 30-year notes.

Consolidated Debt Maturity Schedule — NiSource Inc.

($ Mil.)

Year	Amount
2013	507
2014	559
2015	495
2016	434
2017	507

Source: Fitch.

Summary — NiSource Inc.

	2009	2010	2011	2012	LTM Ended 3/31/2013
Fundamental Ratios (x)					
FFO/Interest Expense	3.41	3.85	4.20	4.00	4.08
CFO/Interest Expense	5.14	2.84	3.29	3.95	3.88
FFO/Debt (%)	14.23	15.31	15.26	15.86	16.40
Operating EBIT/Interest Expense	2.01	2.30	2.39	2.35	2.42
Operating EBITDA/Interest Expense	3.48	3.81	3.80	3.66	3.73
Operating EBITDAR/(Interest Expense + Rent)	3.48	3.81	3.80	3.66	3.73
Debt/Operating EBITDA	4.86	4.88	5.50	5.17	5.02
Common Dividend Payout (%)	116.06	87.67	86.29	65.62	58.47
Internal Cash/Capital Expenditures (%)	182.60	52.58	54.40	66.18	60.38
Capital Expenditures/Depreciation (%)	131.92	149.66	209.11	266.73	281.25
Profitability					
Adjusted Revenues	6,650.00	6,422.00	6,019.00	5,061.00	5,196.00
Net Revenues	3,332.00	3,448.00	3,463.00	3,519.00	3,596.00
Operating and Maintenance Expense	1,653.00	1,655.00	1,722.00	1,663.00	1,711.00
Operating EBITDA	1,395.00	1,506.00	1,446.00	1,568.00	1,597.00
Depreciation and Amortization Expense	589.00	596.00	538.00	562.00	560.00
Operating EBIT	806.00	910.00	908.00	1,006.00	1,037.00
Gross Interest Expense	401.00	395.00	380.00	429.00	428.00
Net Income for Common	218.00	292.00	299.00	416.00	484.00
Operating and Maintenance Expense % of Net Revenues	49.61	48.00	49.73	47.26	47.58
Operating EBIT % of Net Revenues	24.19	26.39	26.22	28.59	28.84
Cash Flow					
Cash Flow from Operations	1,659.00	725.00	870.00	1,265.00	1,234.00
Change in Working Capital	693.00	(401.00)	(344.00)	(20.00)	(82.00)
Funds From Operations	966.00	1,126.00	1,214.00	1,285.00	1,316.00
Dividends	(253.00)	(256.00)	(258.00)	(273.00)	(283.00)
Capital Expenditures	(777.00)	(892.00)	(1,125.00)	(1,499.00)	(1,575.00)
Free Cash Flow	629.00	(423.00)	(513.00)	(507.00)	(624.00)
Net Other Investment Cash Flow	124.00	(52.00)	(33.00)	48.00	173.00
Net Change in Debt	(770.00)	547.00	580.00	78.00	106.00
Net Equity Proceeds	8.00	13.00	21.00	374.00	377.00
Capital Structure					
Short-Term Debt	103.00	1,383.00	1,359.00	777.00	1,131.00
Long-Term Debt	6,684.00	5,970.00	6,594.00	7,326.00	6,893.00
Total Debt	6,787.00	7,353.00	7,953.00	8,103.00	8,024.00
Total Hybrid Equity and Minority Interest	-	-	-	-	-
Common Equity	4,854.00	4,923.00	4,997.00	5,554.00	5,691.00
Total Capital	11,641.00	12,276.00	12,950.00	13,657.00	13,715.00
Total Debt/Total Capital (%)	58.30	59.90	61.41	59.33	58.50
Total Hybrid Equity and Minority Interest/Total Capital (%)	-	-	-	-	-
Common Equity/Total Capital (%)	41.70	40.10	38.59	40.67	41.50

Source: Company reports.

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MOODY'S
INVESTORS SERVICE

Credit Opinion: NiSource Inc.

Global Credit Research - 15 Nov 2013

Merrillville, Indiana (State of), United States

Ratings

Category	Moody's Rating
Outlook	Rating(s) Under Review
Pref. Shelf	*(P)Ba2
NiSource Finance Corporation	
Outlook	Rating(s) Under Review
Issuer Rating	*Baa3
Bkd Sr Unsec Bank Credit Facility	*Baa3
Senior Unsecured	*Baa3
Bkd Commercial Paper	*P-3
NiSource Capital Markets, Inc.	
Outlook	Rating(s) Under Review
Bkd Senior Unsecured	*Baa3
Northern Indiana Public Service Company	
Outlook	Rating(s) Under Review
Issuer Rating	*Baa2
Senior Unsecured	*Baa2
Bay State Gas Company	
Outlook	Rating(s) Under Review
Senior Unsecured	*Baa2

* Placed under review for possible upgrade on November 8, 2013

Contacts

Analyst	Phone
Lesley Ritter/New York City	212.553.1607
William L. Hess/New York City	212.553.3837

Key Indicators

[1]**NiSource Inc.**

	LTM 9/30/2013	2012	2011	2010
(CFO Pre-W/C + Interest) / Interest Expense	**4.3x**	**4.2x**	**3.8x**	**3.9x**
(CFO Pre-W/C) / Debt	**15.9%**	**16.3%**	**13.7%**	**15.7%**
(CFO Pre-W/C - Dividends) / Debt	**12.6%**	**13.3%**	**10.7%**	**12.6%**
Debt / Book Capitalization	**51.5%**	**51.5%**	**53.7%**	**53.6%**

[1] All ratios calculated in accordance with the Global Regulated Electric Utilities Rating Methodology using

Moody's standard adjustments.

Note: For definitions of Moody's most common ratio terms please see the accompanying User's Guide.

Opinion

Rating Drivers

- MLP talk creates credit-negative buzz but commitment to investment grade stands

- Pipelines: system modernization on track for first FERC filing

- LDCs: 2013 rate cases yield rate increases and further improvements in rate design

- NIPSCO: with environmental spending on track, focus turns to longer term capex opportunities

- Bay State: files new rate case seeking to reduce regulatory lag

- Credit metrics to weaken somewhat over near term horizon

Corporate Profile

NiSource Inc. (Baa3 senior unsecured, RUR-Up, for its guaranteed financing vehicles) is a holding company with regulated local natural gas distribution company (LDC) subsidiaries in Ohio, Pennsylvania, Virginia, Massachusetts, Kentucky and Maryland; a combination of a vertically integrated electric and gas utility in Indiana, and an interstate natural gas pipeline and storage system that runs from the Gulf Coast to the Northeast. The company has three segments: Natural gas distribution (LDC, about 40% of operating income), pipelines and gas storage (Pipelines, roughly 40% of operating income) and Electric (about 20% of operating income). While the company has one of the largest LDC, gas pipeline, and gas storage systems in the US, its vertically integrated electric utility is considered mid-sized. Two of NiSource's utility subsidiaries are rated: Bay State Gas Company (Bay State, doing business as Columbia Gas of Massachusetts, Baa2 senior unsecured, RUR-Up) and Northern Indiana Public Service Company (NIPSCO, Baa2 senior unsecured, RUR-Up). Please refer to Moody's Credit Opinion on NIPSCO for more details.

SUMMARY RATING RATIONALE

NiSource's Baa3 rating reflects the diversity and regulated nature of its businesses as well as its improved financial profile. After a decade spent in maintenance mode due to balance sheet constraints following its acquisition of Columbia Energy Group and various operational issues, the company is now showing signs of improvements in its credit metrics and has begun to ramp up its investments in growth opportunities across all three business segments. The more aggressive spending plan will arrest the recent positive trend in credit metrics and keep them anemic for several years. However, we believe that management will maintain financial policies that will prevent its metrics from materially worsening and will take steps to defend its current investment grade rating, if necessary.

DETAILED RATING CONSIDERATIONS

MLP TALK CREATES CREDIT-NEGATIVE BUZZ BUT COMMITMENT TO INVESTMENT GRADE STANDS

From a credit perspective, the MLP corporate finance model is generally viewed as a credit negative because it creates a permanent demand on capital and cash flow growth. For the sponsor, forming an MLP could result in a more complex organizational structure and structural subordination of its debt. Depending on how the sponsor finances the MLP and how it uses the IPO proceeds, the credit implications to the sponsor could be credit neutral, at best.

NiSource is considering forming an MLP, at a time when equity investors are clamoring for MLPs and MLPs have become the prevailing model for financing pipeline investments. For NiSource, at this juncture, the company has signaled the need for equity in late 2015 and an MLP could be a source of equity from an alternative investor base. NiSource is ramping up investments in its large interstate natural gas pipeline system and a nascent midstream business in the Marcellus - Utica shale plays, and owns another long-haul pipe that transports natural gas

between the Gulf and the Mid-Atlantic region. These assets offer steady cash flow that could be dropped into an MLP.

NiSource has been adamant in protecting its investment grade rating, so that if it does form an MLP, we believe the company will proceed cautiously from a small base and gradually growing it through asset drop-downs while keeping a close eye on its consolidated debt levels.

PIPELINES: SYSTEM MODERNIZATION ON TRACK FOR FIRST FERC FILING

The Pipeline segment is NiSource's highest-return operation and historically the most reliable positive cash flow generator among NiSource's three segments. It also has the most long-term growth potential, so more growth capital will be spent in this segment than in the other two.

In 2012, the Pipeline segment received FERC approval for a recovery mechanism backing NiSource's System Modernization Plan. This was an important step for the company, providing it the opportunity to secure a favorable tracker, specifically meant to grant recovery on system modernization investments. This mechanism is of particular relevance to NiSource because the company owns and operates some of the oldest pipes in the country, some of which are located in densely populated areas, where safety is all the more critical. Under the plan, NiSource will spend approximately $300 million a year over the next five years to replace and refurbish its pipelines and compressor stations.

The company will be submitting its first filing with the FERC shortly which, if approved, should result in recovery starting on 2/1/14. Specifically, the cost recovery mechanism entails an annual true-up that is recovered or refunded three months after filing, and a set return on the investment. Although the level of FERC scrutiny applied to this filing will likely be greater given that this is the first time NiSource will be seeking recovery under this tracker, we expect the company will secure full recovery of its investments within the envisioned timeframe.

The System Modernization Plan entailed significant concessions, such as a $25 million refund in each of 2012 and 2013 in addition to base revenue reductions of $35 million beginning in 2012 and another $25 million in 2013. The magnitude of these givebacks will cause NiSource's consolidated cash flow metrics to moderately decline over the next few years, as pipeline cash flows stagnate while spending accelerates.

On the other hand, NiSource continues to pursue a host of growth projects to transport additional gas, leveraging its strategic footprint in the Marcellus and Utica shale production region. While a few existing projects exceed the hundred million mark, the vast majority are of smaller size, similar to the ones it has historically taken on. Most of the midstream projects currently being constructed are on time and on budget and are slated to go online by 2015. In addition to growing its gas transportation system, the company is also diversifying into gathering and processing in the region. These unregulated activities entail more business risk than its core operations, but we expect that any material financial impact from such projects is at least a few years off.

LDCS: 2013 RATE CASES YIELD RATE INCREASES AND FURTHER IMPROVEMENTS IN RATE DESIGN

NiSource's LDCs have become steadier and more profitable over the past several years from rate increases and improved rate designs. Since 2007, a round of rate cases across all jurisdictions has brought rate relief that increased this segment's operating income by 20%, and raised LDCs' consolidated fixed rate recovery to 80%.

In 2013, NiSource's LDCs completed two general rate cases, Pennsylvania (20% of total LDC rate base) and Maryland (1% of total LDC rate base), and filed two more cases in Massachusetts (11% of total LDC rate base) and Kentucky (4% of total LDC rate base). The Pennsylvania order granted the company a $55.3 million base rate increase (70% of its requested amount) and allowed it to adopt a pilot weather normalization adjustment mechanism whereby residential charges are adjusted in the event winter temperatures deviate from historic norms by plus or minus five percent. Importantly, this rate case was the first to be completed under Pennsylvania's Act 11 which allows for more timely recovery of rates and investments through the application of a forward test year. NiSource's new Pennsylvania base rates went into effect in July 2013. The Maryland order granted the company a revenue increase of $3.6 million (70% of its requested amount) as well as a revenue normalization adjustment to decouple revenues from customer usage. Decisions on the two pending rate cases are expected during the first quarter of 2014.

Overall, the different state regulators overseeing NiSource's seven LDCs are generally supportive. Each LDC benefits from a decoupling mechanism and/or weather normalization adjustments which reduce earnings volatility. In addition, NiSource has secured a variety of recovery mechanisms across its different jurisdictions to cover its ongoing infrastructure replacement program providing for the timely recovery of NiSource's annual $500 million

system integrity investment spend.

CREDIT PROFILE OF SIGNIFICANT SUBSIDIARIES

NIPSCO: With Environmental Spending on Track, Focus Turns to Longer Term Capex opportunities

With an electric generation fleet made up of 78% coal, NIPSCO is subject to costly environmental mandates. To meet these directives by the intended deadline, the company is on track to spend about $800 million installing environmental controls at its two coal facilities, Schahfer and Michigan City. Indiana regulation has a long record of providing numerous environmental trackers and other supportive ratemaking mechanisms that have helped the state's coal fleet meet current environmental standards, and we expect NIPSCO will be able to recover these costs in a timely manner. Longer term, as the environmental spend abates, the company will begin acting upon its recently filed 7-year electric and gas plans, representing a total investment amount of $1.8 billion for 2014 to 2020. These investments relate to the recently passed Senate Bill 560 (SB 560), which allows utilities to recover 80% of their investments in transmission and distribution projects for safety, reliability, system modernization, or economic recovery through trackers, with the balance being deferred for recovery in the next general rate case. Finally, in addition to investments under SB 560, NIPSCO continues to develop two electric transmission projects that will earn FERC returns-on-equity of about 12%, about 200 basis points higher than the national average for state regulated operations, and should come online by the end of the decade. For more details see NIPSCO's credit opinion.

BAY STATE: FILES NEW RATE CASE SEEKING TO REDUCE REGULATORY LAG

Bay State filed its latest rate case with the Massachusetts Department of Public Utilities (DPU) in April 2013, requesting a base rate increase of $30.1 million to address the company's earnings deficiency and recover capital costs incurred through 12/31/12. In addition, Bay State's filing includes a proposal to continue its targeted infrastructure recovery factor (TIRF) rider with modifications. The TIRF is designed to provide for recovery of incremental expenditures associated with the replacement of bare and unprotected coated steel, cast-iron, and wrought-iron mains. Specifically, the proposed modifications include increasing the annual cap on amounts collected under the mechanism from 1% to 3.75% of the prior year's distribution revenues; establishing a process by which the company could request a waiver from the DPU of the minimum threshold of 38 miles of main replacement per year; and establishing a process by which post-in-service carrying charges occurring between the in-service date of a TIRF project and the date on which TIRF recovery commences for those projects could be deferred for inclusion in rate base in the next rate case. Bay State expects a DPU decision during the first quarter of 2014.

The company completed its last rate case in November 2012. The DPU granted Bay State a fraction of its requested distribution rate increase, based on a below industry average return on equity of 9.45%. Despite these disappointing outcomes, the DPU's did agree to allow the company to expand the TIRF's definition to include small cast and wrought iron pipes into the program and maintained the decoupling mechanism adopted in 2009, protecting the company's margins from any decline in volumes.

On a consolidated basis, Bay State remains a small component of NiSource, Inc. representing only about 6% of consolidated total assets and, with only $40 million of rated external debt, less than 1% of the overall company's long-term debt.

CREDIT METRICS SOFTEN OVER NEAR TERM HORIZON BUT REMAIN INVESTMENT GRADE

NiSource's credit metrics have been steadily rebounding from the lows seen in 2008-09. The combination of the 50% growth in the company's cash flow from operations pre-working capital (CFO pre-WC) between 2008 and today, and debt levels remaining relatively flat has allowed NiSource to improve its CFO pre-WC to debt ratio from 10.6% in 2008 to 15.8% for the LTM 9/30/13. The company has also successfully de-levered somewhat with its debt to capitalization falling from 55.7% in 2008 to 51.8% as of 9/30/13. On a pro-forma basis, we expect the metrics to weaken as the company seeks to finance its significant capital expenditure plan. Cash flow coverage metrics will likely fall into the low teens while retained cash flow to debt hovers around the 9-10% range. NiSource's debt to capitalization ratio will also likely inch up, though the company has publicly stated its plans to issue additional equity in the second half of 2015 which should help to shore up that metric.

Notching Considerations

NiSource's operating subsidiaries, Bay State and NIPSCO, are rated one notch above NiSource to reflect their lower default probability and the structural seniority of their respective debt to substantially all the parent

guaranteed debt at NiSource Finance Corporation. Bay State's debt is also guaranteed by NiSource, and the utility's debt's higher than expected recovery rates support a rating a notch higher than that of the non-operating holding company that guarantees it.

As shown in the methodology grid below, the grid indicates a rating of Baa2, which does not reflect the structural subordination that causes the actual parent rating to be Baa3. Ratings within the NiSource family are notched closely, because of the company's practice to centrally manage its subsidiaries' cash flow in a corporate money pool and consolidating its debt financing at its guaranteed financing subsidiary NiSource Finance Corporation.

Liquidity Profile

NiSource's liquidity is considered adequate. Given the company's sizeable capital investment program, NiSource has taken multiple steps to improve its access to liquidity to meet its future needs. NiSource amended its revolving credit facility in September 2013, increasing its committed capacity by $500 million to $2.0 billion, and extended the maturity date to September 2018. The company raised its Prime-3 rated commercial paper program to $1.5 billion, up from $500 million in February 2013 and amended its committed bank facility to provide for same day funding to cover the entire $1.5 billion program. Thirdly, NiSource increased its term loan by $75 million to $325 million and extended its maturity by one year to April 2016. And finally, the company renewed its three accounts receivable securitization programs totaling $515 million for another year.

Terms of the revolving credit facility provide for reliable access to funds by not requiring the company to represent and warrant as to any material adverse change (MAC) at each borrowing. The sole financial covenant is a debt-to-capitalization ratio of 70% which the company comfortably satisfied as of 9/30/13, with a debt-to-capitalization ratio of 59.7%.

As of 9/30/13, NiSource had $14.9 million of cash on hand in addition to $1.4 billion of available capacity under its revolver after giving effect to $612.5 million of commercial paper and $21.3 million in letters-of-credit outstanding. NiSource has $500 million of notes due in July 2014 and another $230 million of notes due in November 2015.

For the 12 months ended 9/30/13, NiSource generated approximately $1.4 billion in cash from operations, made approximately $1.8 billion in capital investments, and paid about $300 million in dividends, yielding negative free cash flow of about $700 million. The company funded the cash shortfall through proceeds from discontinued operations, about $40 million from its dividend reinvestment plan program and incremental debt of $600 million.

Rating Outlook

NiSource's rating is under review for a possible upgrade. The RUR-Up reflects our generally more favorable view of the relative credit supportiveness of the US regulatory environment as detailed in Moody's September 23, 2013 Request for Comment: "Proposed Refinements to the Regulated Utilities Rating Methodology and our Evolving View of US Utility Regulation". The outlook also considers the company's current financial plan, which should sustain investment grade metrics, including CFO pre-WC to debt in the low to mid teens.

What Could Change the Rating - Up

NiSource's ratings could be upgraded following the completion of the review for upgrade based on the aforementioned change in Moody's view of the US regulatory environment. Separately, an upgrade could be warranted if NiSource continues to pursue a fully regulated utility business model, with little financial complexity, and if the consolidated ratio of CFO pre-WC to debt were to approach the high-teen's range on a sustainable basis.

What Could Change the Rating - Down

NiSource could be downgraded to the non-investment grade rating category if its ratio of CFO pre-WC to debt fell below 10% for a sustained period of time. This ratio would be looked at on a consolidated basis, and would include any potential MLP structure. Depending on the size of the MLP, and considering any financial or operational volatility that the structure might impart on the company, and the potential effects of any structural subordination, the financial metric thresholds to maintain an investment grade rating might be raised to the low-teen's range. Aside from the risks associated with the potential MLP formation, ratings could be downgraded if the company were to experience deteriorations in its relationship with its principal regulators.

Rating Factors

NiSource Inc.

Regulated Electric and Gas Utilities Industry [1][2]	**LTM 9/30/2013**			**Moody's 12-18 month Forward View* As of November 2013**	
Factor 1: Regulatory Framework (25%)	Measure	Score		Measure	Score
a) Regulatory Framework		Baa			Baa
Factor 2: Ability To Recover Costs And Earn Returns (25%)					
a) Ability To Recover Costs And Earn Returns		Baa			Baa
Factor 3: Diversification (10%)					
a) Market Position (5%)		A			A
b) Generation and Fuel Diversity (5%)		Ba			Ba
Factor 4: Financial Strength, Liquidity And Key Financial Metrics (40%)					
a) Liquidity (10%)		Baa			Baa
b) CFO pre-WC + Interest/ Interest (7.5%)	4.1x	Baa		3.5 - 3.9x	Baa
c) CFO pre-WC / Debt (7.5%)	15.4%	Baa		12 - 14%	Baa
d) CFO pre-WC - Dividends / Debt (7.5%)	12.3%	Baa		9 - 11%	Baa
e) Debt/Capitalization (7.5%)	52.0%	Baa		50 - 55%	Baa
Rating:					
a) Indicated Rating from Grid		Baa2			Baa2
b) Actual Rating Assigned		Baa3			Baa3

* THIS REPRESENTS MOODY'S FORWARD VIEW; NOT THE VIEW OF THE ISSUER; AND UNLESS NOTED IN THE TEXT DOES NOT INCORPORATE SIGNIFICANT ACQUISITIONS OR DIVESTITURES

[1] All ratios are calculated using Moody's Standard Adjustments. [2] As of 9/30/2013(LTM); Source: Moody's Financial Metrics

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Tagging Info

Fitch Affirms NiSource's IDR at 'BBB-'; Outlook Stable

Ratings Endorsement Policy

09 Dec 2013 2:59 PM (EST)

Fitch Ratings-New York-09 December 2013: Fitch Ratings has affirmed the outstanding ratings for NiSource Inc. (NI) and its subsidiaries as listed below. The affirmations include NiSource Finance Corp. (NiSource Finance) and NiSource Capital Markets Inc., NI's two financing subsidiaries, and Northern Indiana Public Service Co. (NIPSCO), an electric and gas utility. The Rating Outlooks remain Stable. Approximately $8.1 billion of long-term debt is affected by this rating action.

KEY RATING DRIVERS:

NI's 'BBB-' Issuer Default Rating (IDR) and Stable Outlook reflect the low business risk and consistent operating performance generated by its geographically diverse mix of regulated operations. Other considerations include the long-term financial impact of aggressive pipeline and gas utility system modernization programs and electric environmental capital expenditures, with a substantial portion of recoveries expected to be received through tracking mechanisms.

Forward Expectations: NI's financial profile is expected to remain consistent with its current rating through its current multi-year infrastructure-build cycle. Fitch projects NI's 2013 debt to EBITDA to be approximately 5.2 times (x). Typically NI's leverage peaks at the end of the year as a result of seasonal gas storage purchases at its gas utilities and drops during the following months as gas costs are recovered. NI's credit metrics in 2013 have benefited from a continuation of bonus depreciation and the sale of its retail services business for $120 million with proceeds used to reduce debt. For 2014 and beyond, maintenance of or modest improvement in leverage metrics will in part depend on some capital market and DRIP equity issuance given NI's substantial capital spending plan which is expected to be in the $1.8 billion to $2 billion annual range for the next several years.

Significant Rate Developments: On April 30, 2013, Indiana SB 560 was signed into law, providing cost recovery outside of base rate proceedings for certain gas and electric utility investments. The law specifically relates to transmission, distribution and storage projects undertaken for the purpose of safety, reliability, system modernization, or economic development. In October 2013, NIPSCO filed a seven-year plan with the Indiana Utility Regulatory Commission (IURC) covering $710 million of eligible gas utility investments. In July 2013, NIPSCO filed a seven-year plan with the IURC covering $1.1 billion of eligible electric utility investments. The IURC gas and electric orders are expected in the 2nd quarter of 2014. Once the plans are approved by the IURC, 80% of the eligible costs can be recovered through tracking mechanisms and 20% deferred for recovery under a general rate cases.

Liquidity: NI's liquidity is expected to be adequate. NiSource Finance has a $2 billion revolving credit facility that matures on Sept. 28, 2018. The revolver was increased to $2 billion from $1.5 billion and its term extended by 16 months through an amendment effective Sept. 30, 2013. The company also issues 'F3' rated commercial paper under a $1.5 billion CP program that is backstopped by the revolver. The revolver has one financial covenant which sets a maximum consolidated debt-to-cap ratio of 70%. The revolver also includes limitations on liens and restrictions on asset sales. At Nov. 30, 2013, NI had approximately $1.6 billion in net available liquidity under the revolver. NI also has a total of $515 million of accounts receivable securitization facilities as follows: $240 million at Columbia Gas of Ohio; $200 at NIPSCO; and $75 million at Columbia Gas of Pennsylvania. The only material debt maturity through 2014 is $500 million of NiSource Finance notes maturing in July 2014.

RATING SENSITIVITIES:

Positive: Future developments that may, individually or collectively, lead to a positive rating action include:

--Reduced regulatory risk with expanded revenue tracking mechanisms;
--Improving credit metrics with sustained leverage at 4.5x or below.

Negative: Future developments that may, individually or collectively, lead to a negative rating action include:

unfavorable regulatory decisions;

--NI not issuing adequate equity to support its significant capital program resulting in sustained leverage above 5.5x.

Fitch has affirmed the following ratings with a Stable Outlook:

NiSource Inc.
--IDR at 'BBB-'.

NiSource Finance Corp.
--IDR at 'BBB-';
--Senior unsecured 'BBB-'
--Short term IDR 'F3';
--Commercial paper 'F3.

NiSource Capital Markets
--IDR 'BBB-';
--Senior unsecured 'BBB-'.

Northern Indiana Public Service Co.
--IDR 'BBB-';
--Senior unsecured and revenue bonds 'BBB'.

Contact:

Primary Analyst
Ralph Pellecchia
Senior Director
+1-212-908-0586
Fitch Ratings, Inc.
One State Street Plaza
New York, NY 1004

Secondary Analyst
Kathleen Connelly
Director
+1-212-908-0290

Committee Chairperson
Sean T. Sexton, CFA
Managing Director
+1-312 368-3130

Media Relations: Brian Bertsch, New York, Tel: +1 212-908-0549, Email: brian.bertsch@fitchratings.com.

Additional information is available at 'www.fitchratings.com'

Applicable Criteria and Related Research:
--'Corporate Rating Methodology, Including Parent and Subsidiary Linkage' Aug. 5, 2013
--'Credit Considerations for the GP/LP Relationship' Nov. 6, 2013;
--'Crossover Credits in Natural Resources' Oct. 31, 2013;
--'Funding U.S. LNG Export Facilities: Credit Issues for MLP and Corporate Sponsors' Aug. 20, 2013;
--'Investor FAQs on Pipeline, Midstream and MLP Sectors' Aug. 5, 2013;
--'Marcellus Shale Report: Midstream and Pipeline Sector Challenges and Opportunities' June 10, 2012.

Applicable Criteria and Related Research:
Corporate Rating Methodology: Including Short-Term Ratings and Parent and Subsidiary Linkage
Credit Considerations for the GP/LP Relationship
Crossover Credits in Natural Resources — Migration Catalysts 2003–2013
Funding U.S. LNG Export Facilities (Credit Issues for MLP and Corporate Sponsors)
Investor FAQs: Recent Questions on the Pipeline, Midstream, and MLP Sectors

Marcellus Shale Report: Midstream and Pipeline Sector -- Challenges/Opportunities

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MOODY'S
INVESTORS SERVICE

Rating Action: Moody's upgrades NiSource and Northern Indiana Public Service and confirms Bay State Gas; outlooks stable

Global Credit Research - 31 Jan 2014

Approximately $9 Billion of Debt Securities Affected

New York, January 31, 2014 -- Moody's Investors Service upgraded the ratings for NiSource Inc. (senior unsecured rating for its guaranteed financing vehicle to Baa2 from Baa3) and Northern Indiana Public Service Company (senior unsecured and Issuer Rating to Baa1 from Baa2), and confirmed the rating for Bay State Gas Company (Baa2 senior unsecured, guaranteed by NiSource Inc.). NiSource Inc.'s commercial paper is also upgraded by one notch (from P-3 to P-2). This rating action concludes our review of these companies' ratings initiated on November 8, 2013. The rating outlooks are stable.

"The upgrade of NiSource and Northern Indiana Public Service Company reflects regulatory provisions in each companies' respective service territory that are consistent with our view of a generally improving regulatory environment for US electric and gas utilities", said Lesley Ritter, Analyst. "While our decision to affirm Bay State's rating relates to the utility's debt being secured by its parent."

RATINGS RATIONALE

The primary driver of today's rating action for Northern Indiana Public Service Company (NIPSCO) and NiSource, Inc. (NiSource) is Moody's more favorable view of the relative credit supportiveness of the US regulatory framework, as detailed in our September 23, 2013 Request for Comment: "Proposed Refinements to the Regulated Utilities Rating Methodology and our Evolving View of US Utility Regulation." Factors supporting this view include better cost recovery provisions, reduced regulatory lag, and generally fair and open relationships between utilities and regulators. The US utility sector's low number of defaults, high recovery rates, and generally strong financial metrics from a global perspective provide additional corroboration of these upgrades.

While the decision to confirm Bay State Gas' (Bay State) rating relates to the company's debt being secured by its Baa2 rated parent.

Rating Outlook

NiSource, NIPSCO, and Bay State's stable rating outlooks reflect the credit supportiveness of the regulatory environment, and the assumption that investment needs will be prudently funded.

Furthermore, NiSource's stable rating outlook considers the company's current financial plan, which should sustain investment grade metrics.

What Could Change the Rating - Up

NiSource and NIPSCO's rating could be raised if there were an improvement in the regulatory environment that led to meaningfully greater predictability, timeliness and/or sufficiency of rates such that financial metrics would be expected to improve on a sustained basis relative to our current view.

NiSource's rating could also be upgraded if the company continues to pursue a fully regulated utility business model, with little financial complexity, and if the consolidated ratio of CFO pre-WC to debt were to approach the high-teen's range on a sustainable basis.

A rating upgrade at Bay State is tied to its parent company rating.

What Could Change the Rating - Down

NiSource and NIPSCO's rating could be lowered if there were a deterioration in the regulatory environment, which might include greater regulatory lag, uncertainty about the recovery of investments, further compression in rates (especially if accompanied by a rise in interest rates), or if there were a downward revision in our expectation of future financial metrics relative to our current view. NISPCO's rating could also come under pressure if its parent

were to adopt an aggressive corporate finance strategy where it would place additional reliance on dividends from its regulated subsidiary to service the parent debt.

Furthermore, NiSource's rating could be downgraded if its ratio of CFO pre-WC to debt fell below 10% for a sustained period of time. This ratio would be looked at on a consolidated basis, and would include any potential MLP structure. Depending on the size of the MLP, and considering any financial and operational volatility that the structure might impart on the company, and the potential effects of any structural subordination, the financial metric threshold to maintain an investment grade rating might be raised to the low-teen's range.

Bay State's rating could be reduced if its parent rating is downgraded.

The principal methodology used in this rating was Regulated Electric and Gas Utilities published in December 2013. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

Debt Classes

NiSource Inc.

Outlook Stable

Pref. Shelf to (P)Ba1 from (P)Ba2

NiSource Finance Corporation

Outlook Stable

Issuer Rating to Baa2 from Baa3

Bkd Sr Unsec Bank Credit Facility to Baa2 from Baa3

Senior Unsecured to Baa2 from Baa3

Bkd Commercial Paper to P-2 from P-3

NiSource Capital Markets, Inc.

Outlook Stable

Bkd Senior Unsecured to Baa2 from Baa3

Senior Unsecured MTN to Baa2 from Baa3

Northern Indiana Public Service Company

Outlook Stable

Issuer Rating to Baa1 from Baa2

Senior Unsecured to Baa1 from Baa2

Senior Secured to A1 from A2

Bay State Gas Company

Outlook Stable

The following ratings have been confirmed

Senior Unsecured Baa2

Senior Unsecured MTN Program (P)Baa2

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Lesley Ritter
Analyst
Infrastructure Finance Group
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

William L. Hess
MD - Utilities
Infrastructure Finance Group
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

Releasing Office:
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

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NiSource Inc.

Primary Credit Analyst:
Gerrit W Jepsen, CFA, New York (1) 212-438-2529; gerrit.jepsen@standardandpoors.com

Secondary Contact:
Michael T Ferguson, CFA, CPA, New York (1) 212-438-7670;
michael.ferguson@standardandpoors.com

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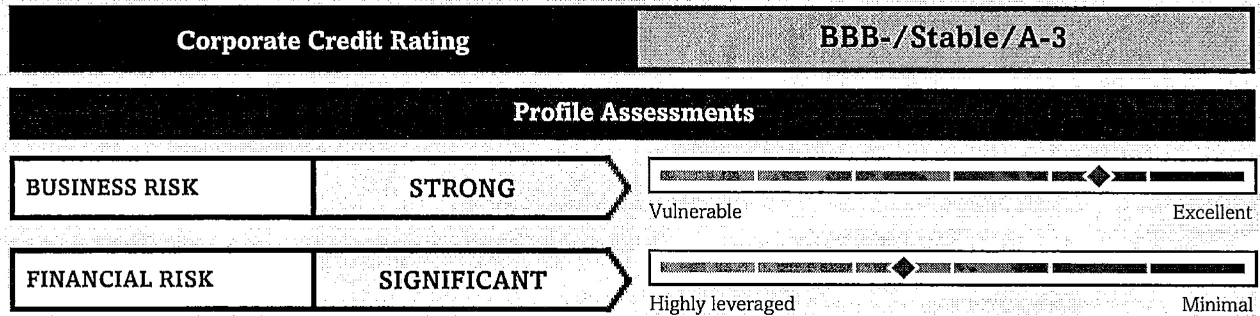
NiSource Inc.



Initial Analytical Outcome ("Anchor") and Rating Result

Our 'BBB-' corporate credit rating on NiSource Inc. is derived from:

- NiSource's 'bbb' anchor based on our assessment that the company's business risk profile is "strong" and its financial risk profile is "significant".
- NiSource's stand-alone credit profile (SACP) of 'bbb-', which is one notch lower than the anchor based on our unfavorable comparable rating analysis, reflecting NiSource's weak financial ratios within the "significant" financial risk profile.
- Our 'BBB-' rating on NiSource is the same as the company's SACP. Group rating methodology applies to NiSource and as the parent company has a final rating that reflects the 'bbb-' SACP.

Rationale

Business Risk: Strong

- Corporate strategy based on regulated utilities and energy midstream operations
- Regulated utilities with mostly low operating risks
- Lack of competition in regulated service territories
- Diverse service area in seven states with numerous regulatory jurisdictions and a large residential customer base
- Gas distribution operations with geographic diversity and integration with the company's gas transmission network, providing operational flexibility
- Electric utility subsidiary Northern Indiana Public Service Co.'s higher-than-average dependence on industrial customers and flat growth at the utility

Financial Risk: Significant

- Expected high debt leverage (debt to EBITDA) more than 5x
- Cash flow to debt measures toward lower end of "significant" financial risk profile
- High capital spending
- Continuing high dividends
- Negative discretionary cash flow

Outlook: Stable

The stable outlook reflects our expectation of steady operating and financial performance at the regulated subsidiaries and annual capital spending of about $1.9 billion. Our base forecast includes funds from operations (FFO) to debt of about 13% and operating cash flow (OCF) to debt of about 12%, consistent with our expectations for the rating.

Downside scenario

We could lower ratings if the company's nonutility operations would materially increase from current levels or financial measures weaken and remain at less-supportive levels, including FFO to debt less than 13%.

Upside scenario

We do not currently contemplate an upgrade given the company's current business mix and its focus on expanding its midstream operations. Credit quality could improve if cash flow measures considerably improve, specifically FFO to debt of more than 17% on a sustained basis. In addition, we would expect the supplemental ratio of OCF to debt to exceed 15%. The company can accomplish this by paying down debt with higher internally generated cash flow, increased equity issuances, or proceeds from asset sales.

Standard & Poor's Base-Case Scenario

Assumptions

- Single digit annual revenue growth over the next few years
- Gross margin growth from rising fee-based midstream operations that do not incur cost of sales
- We expect capital spending of $2 billion in 2014 and roughly the same amount for 2015 and 2016
- Dividend increase based on historical percentage increase
- Common stock issuance annually through the dividend reinvestment plan and as publicly indicated by management, a 2015 offering similar in size to the most recent forward sale settled in 2012 (~$400 million)

Key Metrics

	2014E	2015E	2016E
Revenue growth (%)	3-6	3-6	3-6
FFO/debt (%)	13-14.5	13-14.5	12.7-13.8
OCF/debt (%)	11.2-12.5	11.5-13	10.5-12

Standard & Poor's adjusted figures. E--Estimate. FFO--funds from operations. OCF--Operating cash flow.

Company Description

NiSource Inc. is an energy holding company that is one of the largest natural gas distribution companies in the U.S., with nine gas distribution subsidiaries serving roughly 3.3 million customers in seven states extending from Indiana to

Massachusetts. NiSource owns and operates 15,000 miles of interstate pipelines, and its natural gas storage operations can hold up to 640 billion cubic feet (bcf) of natural gas. Utility subsidiary Northern Indiana Public Service Co. (NIPSCO) provides electricity and natural gas to about 450,000 and 700,000 customers, respectively, in northern Indiana. NiSource Finance Corp. is the financing entity for NiSource Inc., which is the guarantor of all the debt.

Business Risk: Strong

We based our assessment of NiSource's business risk profile on the company's "satisfactory" competitive profile, "very low" industry risk mostly derived from the regulated utility industry, and the "very low" country risk of the U.S. where the company operates.

NiSource's competitive position partly reflects the stable regulatory framework of the low-risk regulated utility operations. We consider the company's gas distribution operations to be above average, characterized by ample geographic diversity and integration with the company's gas transmission network, which provides operational flexibility. Nearly all of the gas distribution subsidiaries' needs are contracted with Columbia Transmission, with roughly 70% of peak gas needs met with storage gas. This bolsters service reliability, thereby supporting the business risk profile. Cash flow variability is also low given material revenue stabilization and cost-tracking mechanisms. NIPSCO is a vertically integrated electric and natural gas utility providing service mostly in Northern Indiana. It has flat customer growth and above-average industrial exposure, largely to the steel-related industry. The utility has been installing environmental compliance equipment and using an environmental rate surcharge for timely recovery of costs. Base rates and various rate surcharges support cost recovery. Rates are above the state average, but not the highest in Indiana.

NiSource's competitive position also reflects the gas midstream businesses, including a gas transmission network that has a huge underground storage system (working gas of about 280 billion cubic feet) and access to multiple supply basins. The company derives slightly more than 90% of revenues from firm take-or-pay contracts, and a moderate contract life exists mainly at maximum rates. These contracts provide more cash flow certainty because gas shippers pay whether or not they have gas to be transported.

S&P Base-Case Operating Scenario

- The economic conditions in the company's service territories are either holding steady or improving, which will likely increase customer usage.
- Base EBITDA is forecast to grow from customer growth, volume-related growth, and expansion projects that are expected to come into service over the forecasted period.
- Utility subsidiaries operate under regulatory terms that largely support credit quality and are generally constructive, which includes good gas adjustment and other cost-pass-through mechanisms. These provide for timely recovery of costs that helps support steady revenues.
- NIPSCO continues spending on new transmission projects and pollution-control equipment while seeking higher operating cash flow through base rates and various rate surcharges. After starting rate recovery of these investments, we forecast that revenue and EBITDA will grow beyond base levels.
- For the gas-gathering business, the largest source of new growth projects will likely be in the Marcellus Shale gas-gathering region, with spending backed by long-term off-take contracts, boosting EBITDA growth.

Peer comparison

Table 1

NiSource Inc. -- Peer Comparison

Industry Sector: Combo

	NiSource Inc.	Sempra Energy	Dominion Resources Inc.	Great Plains Energy Inc.
Ratings as of March 5, 2014	BBB-/Stable/A-3	BBB+/Stable/A-2	A-/Stable/A-2	BBB/Positive/A-2
	--Average of past three fiscal years--			
(Mil. $)				
Revenues	5,834.10	9,562.00	14,223.00	2,294.50
EBITDA	1,661.00	3,587.50	5,195.80	922.30
Funds from operations (FFO)	1,209.80	2,755.50	3,788.00	676.60
Operating income	1,004.40	1,761.60	3,681.60	573.60
Interest expense	462.9	744.6	1,077.80	249.80
Net income from continuing operations	336.3	985	1,565.00	195.30
Working capital	(196.8)	(265.7)	(76.3)	(1.4)
Cash flow from operations	1,171.00	2,259.50	3,116.30	629.30
Capital spending	1,138.30	2,544.00	3,634.30	567.50
Free operating cash flow	32.7	(284.5)	(518.0)	61.80
Dividends paid	262.2	475.7	1,201.90	136.60
Discretionary cash flow	(229.5)	(760.2)	(1719.9)	(74.8)
Cash and short-term investments	4.8	136.6	34.3	2.8
Debt	8,454.60	13,297.80	20,442.70	4,267.40
Preferred stock	0	62.8	976.7	211.2
Equity	5,182.90	10,070.20	12,408.40	3,273.80
Adjusted ratios				
Compound annual revenue growth (%)	(8.7)	6.0	(4.7)	5.5
EBITDA margin (%)	28.5	37.5	36.5	40.2
Return on capital (%)	6.5	7.7	10.4	7.2

Table 1

NiSource Inc. -- Peer Comparison (cont.)				
EBITDA interest coverage (x)	3.6	4.8	4.8	3.7
EBITDA cash interest coverage (x)	4.3	7	5.2	3.5
FFO cash interest coverage (x)	4.3	6.8	4.9	3.6
Debt/EBITDA (x)	5.1	3.7	3.9	4.6
FFO/debt (%)	14.3	20.7	18.5	15.9
Cash flow from operations/debt (%)	13.9	17	15.2	14.7
Free operating cash flow/debt (%)	0.4	(2.10)	(2.50)	1.4
Discretionary cash flow/debt (%)	(2.7)	(5.7)	(8.4)	(1.8)
Total debt/debt plus equity (%)	62	56.9	62.2	56.6

Financial Risk: Significant

Based on the Medial Volatility financial ratio benchmarks, our assessment of NiSource's financial risk profile is "significant". This takes into consideration the sustained cash flows from the regulated utility operations and mostly fee-based midstream businesses. Also, we based the designation on the company's aggressive capital spending program and a dividend payout that exceeds 50%. We expect NiSource to continue having negative free operating cash flow over the next three years. Although we expect equity to grow, we also expect the company to continue using debt financing.

For 12 months ended Sept. 30, 2013, FFO to debt was 15.5% and operating cash flow to debt was 14.7%. Our baseline forecast includes weakening financial measures such as FFO to debt ranging between 12.5% and 14% over the next three years and operating cash flow to debt ranging from 11% to 13% over the same period. The weakening financial measures include the effects of rising expenses including interest and taxes.

S&P Base-Case Cash Flow And Capital Structure Scenario

- NiSource's cash flow ratios will remain consistent with the "significant" financial risk profile in 2014 and 2015, and mixed for 2016. This includes an FFO to debt ratio ranging from roughly 12.5% to 14% and operating cash flow to debt ranging from 11% to 13%.
- Cash flow after capital spending and dividends, discretionary cash flow, will be negative over the next three years, resulting external funding needs.
- Debt leverage as indicated by debt to EBITDA expected to remain above 5x each year over the next three years.

Financial summary

Table 2

NiSource Inc. -- Financial Summary

Industry Sector: Combo

	September 2013 RTM	2012	2011	2010	2009
Rating history	BBB-/Stable/A-3	BBB-/Stable/A-3	BBB-/Stable/A-3	BBB-/Stable/NR	BBB-/Stable/NR

Table 2

NiSource Inc. -- Financial Summary (cont.)

(Mil. $)					
Revenues	5,463.70	5,061.20	6,019.10	6,422.00	6,649.40
EBITDA	1,800.10	1,743.30	1,572.20	1,667.40	1,595.30
Funds from operations (FFO)	1,469.30	1,371.10	1,036.20	1,222.20	1,287.80
Operating income	1,113.80	1,068.90	945.5	998.8	966.5
Interest expense	475.2	482.3	431.4	475.1	517.4
Net income from continuing operations	463.6	410.6	303.8	294.6	231.2
Cash flow from operations	1,394.50	1,261.90	1,184.80	1,066.40	2,144.60
Capital spending	1,761.70	1,491.70	1,122.10	801.1	775.3
Free operating cash flow	(367.2)	(229.8)	62.7	265.3	1,369.30
Dividends paid	302	273.2	257.8	255.6	253.3
Discretionary cash flow	(669.2)	(503.0)	(195.1)	9.7	1,116.00
Cash and short-term investments	3.7	9.1	2.9	2.3	4.1
Debt	9,482.90	8,844.70	8,463.40	8,055.80	8,048.00
Preferred stock	0	0	0	0	0
Equity	5,700.90	5,554.30	5,011.50	4,982.80	5,046.10
Debt and equity	15,183.80	14,399.00	13,475.00	13,038.60	13,094.10
Adjusted ratios					
EBITDA margin (%)	32.3	34.4	26.1	26	24
EBITDA interest coverage (x)	2.9	3.6	3.6	3.5	3.1
EBITDA cash interest coverage (x)	2.2	4.4	4.2	4.2	4.2
FFO cash interest coverage (x)	2.3	4.7	3.9	4.3	4.7
Debt/EBITDA (x)	6.8	5.1	5.4	4.8	5
FFO/debt (%)	15.5	15.5	12.2	15.2	16
Cash flow from operations/debt (%)	14.7	14.3	14	13.2	26.6
Free operating cash flow/debt (%)	(3.9)	(2.6)	0.7	3.3	17
Discretionary cash flow/debt (%)	(7.1)	(5.7)	(2.3)	0.1	13.9
Net cash flow/capital spending (%)	66.3	73.6	69.4	120.7	133.4
Debt/debt and equity (%)	62.5	61.4	62.8	61.8	61.5
Return on capital (%)	6.6	6.6	6.1	6.7	6.5
Return on common equity (%)	8.3	7.6	6.1	6	4.7
Common dividend payout ratio (unadjusted) (%)	65.2	66.6	85	86.8	109.6

RTM--Rolling 12 months.

Liquidity: Adequate

NiSource has "adequate" liquidity, as our criteria define the term. The company's sources of liquidity are likely to cover its uses by more than 1.1x in the next 12 months. We expect NiSource to meet cash outflows even with a 10% decline in EBITDA.

There are sizeable debt maturities in 2014 and 2016; however, we expect the company to refinance these given its satisfactory standing in the credit markets.

Principal Liquidity Sources	Principal Liquidity Uses
• Forecasted FFO of about $1.3 billion in 2014 • Availability under credit facility of about $1.3 billion in 2014	• Maintenance capital spending of about $1.1 billion in 2014 • About $320 million in dividends in 2014 • Debt maturities of $540 million in 2014

Debt maturities

- 2014: $542.1 mil.
- 2015: $265.5 mil.
- 2016: $755.0 mil.
- 2017: $597.8 mil.
- 2018: $808.7 mil.

Covenant Analysis

NiSource's credit facility and a three-year term loan have a covenant of maximum debt to total capital of 70%. As of year-end 2013, the ratio was 60%.

We believe headroom could erode somewhat if debt rises rapidly, without adequate growth in equity while making capital investments.

Compliance Expectations	Schedule Of Step-Downs/Step-Ups
• The company was in compliance as of Dec. 31, 2013 • Single-digit EBITDA growth and elevated capital spending should still permit a cushion • Covenant headroom could decrease without adequate cost recovery of capital investments	• Current: 70% • As of year-end 2014: 70% • As of year-end 2015: 70%

Other Modifiers

NiSource's ratings include a one-notch negative adjustment for comparable rating analysis that reflects NiSource's weak financial ratios within the "significant" financial risk profile.

Group Influence

Standard & Poor's bases its ratings on NiSource on the consolidated group credit profile and application of our group ratings methodology. NiSource, as the parent company, has a GCP that matches its SACP. NIPSCO and Bay State Gas Co. are "core" subsidiaries to the NiSource group and therefore the subsidiaries' issuer credit ratings are equal to the NiSource GCP.

Ratings Score Snapshot

Corporate Credit Rating: BBB-/Stable/A-3

Business risk: Strong

- Country risk: Very low
- Industry risk: Very low
- Competitive position: Satisfactory

Financial risk: Significant

- Cash flow/leverage: Significant

Anchor: 'bbb'

Modifiers

- Diversification/portfolio effect: Neutral (no impact)
- Capital structure: Neutral (no impact)
- Liquidity: Adequate (no impact)
- Financial policy: Neutral (no impact)
- Management and governance: Satisfactory (no impact)
- Comparable rating analysis: Negative (-1 notch)

Stand-alone credit profile: 'bbb-'

- Group credit profile: 'bbb-'
- Entity status within group: Parent

Related Criteria And Research

Related Criteria

- Criteria - Corporates - Utilities: Key Credit Factors For The Regulated Utilities Industry, Nov. 19, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- General Criteria: Methodology: Industry Risk, Nov. 19, 2013
- Criteria - Corporates - General: Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Nov. 19, 2013

- Criteria - Corporates - General: Corporate Methodology, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- General Criteria: Methodology For Linking Short-Term And Long-Term Ratings For Corporate, Insurance, And Sovereign Issuers, May 7, 2013
- General Criteria: Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- General Criteria: Stand-Alone Credit Profiles: One Component Of A Rating, Oct. 1, 2010
- Criteria - Corporates - Utilities: Notching Of U.S. Investment-Grade Investor-Owned Utility Unsecured Debt Now Better Reflects Anticipated Absolute Recovery, Nov. 10, 2008
- Criteria - Corporates - General: 2008 Corporate Criteria: Rating Each Issue, April 15, 2008
- Criteria - Corporates - General: 2008 Corporate Criteria: Commercial Paper, April 15, 2008

Ratings Detail (As Of March 14, 2014)	
NiSource Inc.	
Corporate Credit Rating	BBB-/Stable/A-3
Commercial Paper	
Local Currency	A-3
Senior Unsecured	BBB-
Corporate Credit Ratings History	
28-Jul-2011	BBB-/Stable/A-3
05-Mar-2009	BBB-/Stable/NR
16-Dec-2008	BBB-/Negative/NR
Related Entities	
Bay State Gas Co.	
Issuer Credit Rating	BBB-/Stable/NR
Senior Unsecured	BBB-
NiSource Capital Markets Inc.	
Issuer Credit Rating	BBB-/Stable/NR
Senior Unsecured	BBB-
NiSource Finance Corp.	
Issuer Credit Rating	BBB-/Stable/A-3
Northern Indiana Public Service Co.	
Issuer Credit Rating	BBB-/Stable/NR
Senior Unsecured	A/Stable
Senior Unsecured	BBB-

*Unless otherwise noted, all ratings in this report are global scale ratings. Standard & Poor's credit ratings on the global scale are comparable across countries. Standard & Poor's credit ratings on a national scale are relative to obligors or obligations within that specific country.

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FitchRatings

Corporates

Electric-Corporate / U.S.A.

NiSource Inc.

NiSource Finance Corp. and NiSource Capital Markets, Inc.

Full Rating Report

Ratings

NiSource Inc.

Long-Term IDR	BBB–

NiSource Finance Corp.

Long-Term IDR	BBB–
Short-Term IDR and Commercial Paper	F3
Senior Unsecured	BBB–

NiSource Capital Markets, Inc.

Long-Term Rating	BBB–
Senior Unsecured	BBB–

IDR – Issuer Default Rating.

Rating Outlooks

Stable

Financial Data

NiSource Inc.

(x)	12/31/12	12/31/13
EBITDA/Interest	3.6	3.8
FFO Coverage	4.0	4.3
Debt/EBITDA	5.2	5.3
Debt/FFO	6.3	6.4

Related Research

Northern Indiana Public Service Company (April 2014)

Rating Pipelines, Midstream and MLPs — Sector Credit Factors (January 2014)

Analysts

Ralph Pellecchia
+1 212 908-0586
ralph.pellecchia@fitchratings.com

Kathleen Connelly
+1 212 908-0290
kathleen.connelly@fitchratings.com

Key Rating Drivers

Low Business Risk: NiSource Inc.'s (NI) rating and Stable Outlook reflect the low business risk and consistent operating performance generated by its geographically diverse mix of regulated operations. Other considerations include the long-term financial impact of aggressive pipeline and gas utility system modernization programs and electric environmental capex, with a substantial portion of recoveries expected to be received through tracking mechanisms.

Forward Expectations: Fitch Ratings expects NI's financial profile to remain consistent with its current rating though its current multiyear infrastructure-build cycle. Fitch projects NI's 2014 debt to EBITDA to remain level with 2013 at approximately 5.3x. Maintenance of or modest improvement in leverage metrics will in part depend on some equity issuance, given NI's substantial capital plan, which is in the $1.8 billion–$2.2 billion annual range for the next several years.

Favorable Rate Developments: Indiana allows cost recovery outside of base rate proceedings for gas and electric utility investments relating to safety, reliability, system modernization, or economic development. NI subsidiary Northern Indiana Public Service Co. (NIPSCO) filed a seven-year plan with the Indiana Utility Regulatory Commission (IURC) in October 2013 covering $710 million of eligible gas utility investments.

Electric Plan Approved: NIPSCO filed a seven-year plan with the IURC in July 2013 covering $1.1 billion of eligible electric utility investments. The electric plan was approved in February 2014, and a gas order is expected in the second quarter of 2014. Under the plans, 80% of the eligible costs can be recovered through tracking mechanisms and 20% deferred for recovery under general rate cases.

Rating Outlook: NI's Stable Rating Outlook reflects expectations for consistent operating performance across all three business segments supported by favorable regulation.

Rating Sensitivities

Positive Rating Action: Future developments that may, individually or collectively, lead to a positive rating action include reduced regulatory risk with expanded revenue tracking mechanisms and improving credit metrics with sustained leverage at 4.5x or below.

Negative Rating Action: Future developments that may, individually or collectively, lead to a negative rating action include unfavorable regulatory decisions and NI not issuing adequate equity to support its significant capital program, resulting in sustained leverage above 5.5x.

Issuer Rating History

Date	LT IDR (FC)	Outlook/ Watch
Dec. 9, 2013	BBB–	Stable
Dec. 11, 2012	BBB–	Stable
Dec. 13, 2011	BBB–	Stable
Dec. 14, 2010	BBB–	Stable
Dec. 15, 2009	BBB–	Stable
Feb. 4, 2009	BBB–	Stable
May 14, 2008	BBB	Stable
July 10, 2007	BBB	Stable
March 31, 2006	BBB	Stable
Dec. 6, 2005	BBB	Stable
Sept. 21, 2005	BBB	Stable
June 30, 2003	BBB	Stable
Feb. 6, 2002	BBB	RWN
Dec. 6, 2001	BBB	Stable
Oct. 27, 2000	BBB+	Stable

LT IDR – Long-term Issuer Default Rating.
FC – Foreign currency.
RWN – Rating Watch Negative.
Source: Fitch.

Financial Overview

Liquidity

Fitch expects NI's liquidity to be adequate. NI affiliate NiSource Finance Corp. (NiSource Finance) has a $2 billion revolving credit facility that matures on Sept. 28, 2018. The revolver was increased to $2 billion from $1.5 billion and its term extended by 16 months through an amendment effective Sept. 30, 2013. The company also issues 'F3' rated commercial paper (CP) under a $1.5 billion CP program backstopped by the revolver. The revolver has one financial covenant that sets a maximum consolidated debt-to-capitalization ratio of 70%. The revolver also includes limitations on liens and restrictions on asset sales. NI had approximately $1.55 billion in net available liquidity under the revolver at Dec. 31, 2013.

NI also has a total of $515 million of accounts receivable securitization facilities as follows: $240 million at Columbia Gas of Ohio; $200 million at NIPSCO; and $75 million at Columbia Gas of Pennsylvania. The only material debt maturity through 2014 is $500 million of NiSource Finance notes maturing in July 2014.

Debt Maturities and Liquidity

($ Mil., At Dec. 31, 2013)

Debt Maturities	
2014	542.1
2015	265.5
2016	755.0
2017	597.8
After 2017	6,028.6
Cash and Cash Equivalents	27.0
Undrawn Committed Facilities	1,566.0

Source: Fitch.

Cash Flow Analysis

Fitch expects NI to generate sustainable 5%–7% earnings growth annually through its low-risk investment portfolio. FFO should be relatively stable, with increasing EBITDA somewhat offset with lower deferred tax and investment tax credits, and increased pension contributions in 2015 and 2016.

Key Rating Issues

Issue	Pipeline Modernization Settlement approved by FERC.
Timeline	Long term
Rating Impact	Positive
Summary	FERC approved a five-year pipeline customer settlement in January 2013, covering $1.5 billion in investment. The settlement covers the initial five years of a 10- to 15-year program totaling $4 billion–$5 billion. The 2013 modernization investment of $300 million is on track. A tracker filing was made by year-end 2013, and recovery began in February 2014.
Issue	Passage of Infrastructure Investment Legislation in Indiana.
Timeline	Long term
Rating Impact	Positive
Summary	Indiana SB560 allows for the recovery through deferrals and tracker mechanisms of electric system modernization expenditures. NIPSCO filed a $1.1 billion, seven-year plan with the IURC in October 2013, focused on replacing poles, transformers, and other related equipment. Fitch expects the plan to be approved, and investments are scheduled to begin in 2014.
Issue	Capital Investment Program
Timeline	Long term
Rating Impact	Neutral
Summary	NI is undertaking a significant capex program across all three segments ($1.8 billion–$2.2 billion annually), primarily to ensure system maintenance and modernization. Risk is reduced via tracking mechanisms and rate case determinations, resulting in highly predictable cash flow streams. However, given the size of these programs, NI will need to periodically issue equity to maintain current leverage ratios.

FERC – Federal Energy Regulatory Commission. IURC – Indiana Utility Regulatory Commission.
NIPSCO –Northern Indiana Public Service Co.
Source: Fitch.

Related Criteria

Corporate Rating Methodology: Including Short-Term Ratings and Parent and Subsidiary Linkage (August 2013)

Company Profile

NI is an energy holding company whose subsidiaries provide natural gas and electricity to 3.8 million customers. Rate-regulated asset-based businesses generate more than 95% of operating income. NI had 8,477 employees at Dec. 31, 2013, of whom 3,318 were subject to collective bargaining agreements.

Gas Distribution Operations; 39% of Operating Earnings for 2013

NI owns six distribution companies through its wholly owned subsidiary, Columbia Energy, serving a total of 2.6 million customers in Ohio, Pennsylvania, Virginia, Kentucky, Massachusetts, and Maryland. NI also distributes gas to 803,000 customers in northern Indiana through NIPSCO.

Columbia Pipeline Group Operations; 39% of Operating Earnings for 2013

NI owns and operates approximately 15,000 miles of interstate pipeline and 642 Bcf of natural gas storage through Columbia Gas Transmission Corp. (Columbia Transmission), Columbia Gulf Transmission Co. (Columbia Gulf), NiSource Midstream, and Crossroads Pipeline. NI is also the 47.5% owner of the 182-mile Millennium Pipeline, along with National Grid plc and DTE Energy Co. The pipeline network extends from offshore in the Gulf of Mexico to Lake Erie in New York and the eastern seaboard, and serves 16 states and the District of Columbia. More than 90% of transmission revenues are derived from contracted capacity reservation fees.

NiSource Midstream is an unregulated provider of midstream services, including gathering, treating, processing, conditioning, compression, and liquids handling. It supports the growing production in the Utica and Marcellus shale basins and constructed 57 miles of gathering pipeline capable of delivering 425 million cubic feet of gas per day (mmcf/d) from Marcellus production. NiSource Midstream has a joint venture with 50 miles of wet gas gathering pipeline capable of gathering 600 mmcf/d, a processing plant with 200 mmcf/d capacity, and an NGL pipeline with 45,000 barrels per day of initial capacity.

Electric Operations; 22% of Operating Earnings for 2013

NIPSCO generates, transmits, and distributes electricity to 460,000 customers in northern Indiana. NIPSCO operates three coal-fired electric generation stations with a net capability of 2,540 MW, four gas-fired units with a net capability of 206 MW, two hydro plants with a net capability of 10 MW and the 535-MW combined-cycle gas turbine (CCGT) Sugar Creek plant in Indiana purchased in May 2008. These facilities provide for a total system operating net capability of 3,291 MW. NIPSCO generated 77.3% and purchased 22.7% of its electric requirements during 2013. NIPSCO participates in the Midwest Independent System Operator transmission service and wholesale energy market.

Management Strategy

NI's key financial baselines are:

- A commitment to investment-grade ratings;
- A balanced approach (debt/equity) to funding the capex program;
- Dividend growth of 3%–5%;
- Formation of a master limited partnership to own certain Columbia Pipeline Group assets will likely be decided later this year.

Areas of Focus by Business Segment

Gas Distribution

The company will continue to execute on infrastructure investments and regulatory initiatives. Investment-driven growth with cost recovery through tracking mechanisms is low risk and provides timely returns. As spending on pipeline safety increases, NI is well positioned in key jurisdictions to make the appropriate improvements with full recovery.

Electric Operations

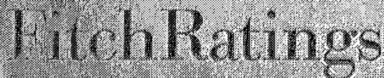
NI will focus on completing environmental investments and modernizing infrastructure with trackers in place, and will initiate low-risk transmission projects. The electric rate case settlement approved in late 2011 lowers volatility with a rate structure more weighted toward residential load.

Columbia Pipeline Group

NI will leverage the value of existing assets and mineral rights. This particularly applies to pipeline and storage assets in the growing Utica and Marcellus basins, and new growth projects designed to support increasing production. The company will focus on fee-based services. In addition, pipeline replacement or modernization expenditures should be fully recovered in rates.

Business Trends

Fitch's 2014 outlooks for gas utilities, electric utilities, and natural gas pipelines are stable. Expected growth in gas production from the Marcellus and Utica basins will provide NI with opportunities to develop regional infrastructure.



Financial Summary — NiSource Inc.

($ Mil., Fiscal Years Ended Dec. 31)	2009	2010	2011	2012	2013
Fundamental Ratios (x)					
FFO/Interest Expense	3.41	3.85	4.20	4.00	4.16
CFO/Interest Expense	5.14	2.84	3.29	3.95	4.31
FFO/Debt (%)	14.23	15.31	15.26	15.86	15.53
Operating EBIT/Interest Expense	2.01	2.30	2.39	2.35	2.51
Operating EBITDA/Interest Expense	3.48	3.81	3.80	3.66	3.84
Operating EBITDAR/(Interest Expense + Rent)	3.48	3.81	3.80	3.66	3.84
Debt/Operating EBITDA	4.86	4.88	5.50	5.17	5.30
Common Dividend Payout (%)	116.06	87.67	86.29	65.62	57.52
Internal Cash/Capital Expenditures (%)	182.60	52.58	54.40	66.18	60.16
Capital Expenditures/Depreciation (%)	131.92	149.66	209.11	266.73	325.82
Profitability					
Adjusted Revenues	6,650.00	6,422.00	6,019.00	5,061.00	5,657.00
Net Revenues	3,332.00	3,448.00	3,463.00	3,519.00	3,841.00
Operating and Maintenance Expense	1,653.00	1,655.00	1,722.00	1,663.00	1,874.00
Operating EBITDA	1,395.00	1,506.00	1,446.00	1,568.00	1,666.00
Depreciation and Amortization Expense	589.00	596.00	538.00	562.00	577.00
Operating EBIT	806.00	910.00	908.00	1,006.00	1,089.00
Gross Interest Expense	401.00	395.00	380.00	429.00	434.00
Net Income for Common	218.00	292.00	299.00	416.00	532.00
Operating and Maintenance Expense % of Net Revenues	49.61	48.00	49.73	47.26	48.79
Operating EBIT % of Net Revenues	24.19	26.39	26.22	28.59	28.35
Cash Flow					
Cash Flow from Operations	1,659.00	725.00	870.00	1,265.00	1,437.00
Change in Working Capital	693.00	(401.00)	(344.00)	(20.00)	65.00
Funds From Operations	966.00	1,126.00	1,214.00	1,285.00	1,372.00
Dividends	(253.00)	(256.00)	(258.00)	(273.00)	(306.00)
Capital Expenditures	(777.00)	(892.00)	(1,125.00)	(1,499.00)	(1,880.00)
FCF	629.00	(423.00)	(513.00)	(507.00)	(749.00)
Net Other Investment Cash Flow	124.00	(52.00)	(33.00)	48.00	(30.00)
Net Change in Debt	(770.00)	547.00	580.00	78.00	719.00
Net Equity Proceeds	8.00	13.00	21.00	374.00	36.00
Capital Structure					
Short-Term Debt	103.00	1,383.00	1,359.00	777.00	699.00
Long-Term Debt	6,684.00	5,970.00	6,594.00	7,326.00	8,135.00
Total Debt	**6,787.00**	**7,353.00**	**7,953.00**	**8,103.00**	**8,834.00**
Total Hybrid Equity and Minority Interest	—	—	—	—	—
Common Equity	4,854.00	4,923.00	4,997.00	5,554.00	5,886.00
Total Capital	**11,641.00**	**12,276.00**	**12,950.00**	**13,657.00**	**14,720.00**
Total Debt/Total Capital (%)	58.30	59.90	61.41	59.33	60.01
Total Hybrid Equity and Minority Interest/Total Capital (%)	—	—	—	—	—
Common Equity/Total Capital (%)	41.70	40.10	38.59	40.67	39.99

Source: Company reports.

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MOODY'S
INVESTORS SERVICE

Rating Action: Moody's affirms NiSource Baa2 rating after corporate separation announcement; outlook remains stable

Global Credit Research - 29 Sep 2014

New York, September 29, 2014 -- Moody's Investors Service affirmed the Baa2 senior unsecured rating of NiSource Inc. after the announcement of a planned corporate separation. The rating outlook is stable.

RATINGS RATIONALE

The rating action is triggered by the recent announcement that NiSource is planning on a corporate separation. NiSource intends to split into two publicly traded companies: NiSource Inc.: a holding company with a portfolio of fully regulated electric and natural gas distribution utility subsidiaries; and Columbia Pipeline Group (CPG): a pure play natural gas pipeline, midstream and storage company.

The Baa2 rating also reflects another NiSource announcement, which is aimed at further restructuring CPG. The company is moving forward with the formation of a master limited partnership (MLP), prior to the corporate separation, to help fund CPG's extensive capital investment plans. Post corporate separation, the MLP will remain with CPG.

"The Baa2 rating affirmation of NiSource primarily reflects the credit profile of the electric and gas distribution utility businesses" said Lesley Ritter, Analyst. "The utility's $7.8 billion rate base benefits from supportive regulatory jurisdictions and this supportiveness helps mitigate NiSource's weaken pro-forma financial profile."

NiSource's legacy regulated low risk utility assets, including six local distribution gas companies (equivalent to 55% of rate base) and one vertically integrated electric and gas distribution utility Northern Indiana Public Service Company (Baa1, stable), are viewed as material credit positives. The regulatory authorities overseeing the utilities are supportive to long-term credit quality, provide an attractive suite of timely recovery mechanisms for costs and investments (approximately 70% of capital expenditures are recovered through trackers), and equity returns are authorized at levels at or above the national average.

NiSource also benefits from good geographical diversity and size, with a footprint spanning seven states across the Northeast quadrant of the US. Approximately 65% of the company will be represented by low risk natural gas distribution business, with the remainder being a vertically integrated electric utility in Indiana.

The rating is constrained by NiSource's weak financial profile, primarily relating to its elevated debt levels.

"NiSouce's high debt level appears to be permanent, and will keep some pressure on consolidated financial metrics, including a ratio of cash flow to debt in the 11-12% range over the next few years." Ritter added.

NiSource's extensive capital investment projects will keep some pressure on the financial profile for the foreseeable future, given the lag in cash flow generation relative to the company's debt. Furthermore, we expect the company to apply a conservative approach to its capital investments funding, including equity issuances if necessary. Overall, Moody's views the company's sound operational track record, low business risk, and constructive and diversified regulatory relationships as providing sufficient support for it to offset a financial profile that is weaker than the company's rating on a sustained basis.

The stable rating outlook reflects our expectation that the financial profile will improve over the next three to five years, with a debt to capitalization ratio of approximately 50% and a ratio of cash flow to debt slowly rising closer to the low-teens range. The stable outlook reflects an anticipated smooth corporate separation, and incorporates a view that NiSource's regulated utility capital expenditure plans will be financed with a balanced mix of debt and equity. The outlook also takes into account the credit supportiveness of NiSource's regulatory environments, the low business risk associated with its LDC operations, and the scale and scope of its footprint, which together mitigate metrics that are weak for the rating category.

What Could Change the Rating -- Up

An upgrade could be considered if there was further improvement in the utility's regulatory environment or if cash

flow to debt rise to the high teens and interest coverage exceeds 4.0x on a sustained basis.

What Could Change the Rating -- Down

The rating could be downgraded if there is a decline in credit supportiveness of NiSource's regulatory environments, an adverse change in the company's business mix or corporate structure such that its business risk profile deteriorates, or if debt coverage and interest coverage ratios fall below 12% and 3.0x, on a sustained basis.

The principal methodology used in these ratings was the Regulated Electric and Gas Utilities published in December 2013. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

Outlook Actions:

..Issuer: NiSource Finance Corporation

....Outlook, Remains Stable

Affirmations:

..Issuer: NiSource Finance Corporation

.... Issuer Rating, Affirmed Baa2

....Senior Unsecured Bank Credit Facility, Affirmed Baa2

....Senior Unsecured Commercial Paper, Affirmed P-2

....Senior Unsecured Regular Bond/Debenture, Affirmed Baa2

....Senior Unsecured Shelf, Affirmed (P)Baa2

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Lesley Ritter
Analyst
Infrastructure Finance Group
Moody's Investors Service, Inc.

250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

William L. Hess
MD - Utilities
Infrastructure Finance Group
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

Releasing Office:
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

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FII Fitch Affirms NiSource at 'BBB-' on Spin-off Announcement
Sep 29 2014 14:44:55

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BN 09/29 14:45 *NISOURCE RATING OUTLOOK STABLE BY FITCH
BN 09/29 14:44 *FITCH AFFIRMS NISOURCE AT 'BBB-' ON SPIN-OFF ANNOUNCEMENT
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FITCH AFFIRMS NISOURCE'S IDR AT 'BBB-' WITH STABLE OUTLOOK FOLLOWING SPIN-OFF ANNOUNCEMENT

Fitch Ratings-New York-29 September 2014: Fitch Ratings has affirmed the long-term Issuer Default Ratings (IDRs) of NiSource Inc. (NI) and its subsidiaries following its announcement to separate the natural gas pipeline business Columbia Pipeline Group (CPG) into a standalone company. After the separation, NI will become a fully regulated natural gas and electric utility holding company.

The affirmations include NiSource Finance Corp. (NIF or NI Finance) and NiSource Capital Markets Inc. (NICM), NI's two financing subsidiaries, and Northern Indiana Public Service Co. (NIPSCO), an electric and gas utility. Fitch has also affirmed the senior unsecured rating of NIPSCO at 'BBB' and assigned an 'F3' short-term IDR to NI.

The Rating Outlook for all entities is Stable. Approximately $8.2 billion of long-term debt is affected. A complete list of rating actions is provided at the end of this release.

Additionally, based on preliminary information from NI management, Fitch expects CPG to be rated low investment grade.

KEY RATING DRIVERS:

Lower Business Risk with Evolving Capital Structure:

Fitch views favorably that the expected fully regulated operations are lower risk than its present mix of businesses, supported by stable cash flow and earnings from a geographically diverse mix of regulated gas and electric utilities.

However, Fitch believes positive rating actions are premature at this time as NI's capital structure is expected to continue to evolve. A potential positive rating movement is highly dependent upon the final capital structure after the spinoff, the willingness to issue adequate equity to support its capital spending commitments, and the successful execution of the pre-spin strategies, including the public offering of the master limited partnership initially consisting of a 14.6% interest in CPG.

Supportive Regulatory Environment:

The ratings and Outlook reflect the supportive regulatory framework that NI's utilities enjoy in their respective jurisdictions, in light of the aggressive gas and electric system safety and modernization programs and NIPSCO's environmental capex.

The gas utility operations have reduced cyclicality and earned stable cash flow through de-coupling mechanisms and trackers. Most recently, Massachusetts HB 4164 was passed in June 2014 and supports gas infrastructure safety and modernization investment and allows for recovery between rate cases and reduces regulatory lag. Columbia Gas of Massachusetts (CMA) plans to file an infrastructure plan by year end 2014 with an anticipated effective date in early 2015.

Indiana SB 560 provides cost recovery outside of base rate proceedings for transmission, distribution and storage projects undertaken for the purpose of safety, reliability, system modernization, or economic development.

NIPSCO's gas and electric operations are operating under seven-year plans that expire in November 2020 totaling $1.8 billion ($1.1 billion electric investments

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and $710 million gas investments) for replacement and maintenance of utility equipment, with approximately 75% recovery through trackers and the remaining deferred for recovery under a general rate case. NIPSCO's approved environmental spending plan includes over $600 million for generating plant investment which is 100% recoverable through a tracker. Fitch has assumed that the utilities are able to continue to earn returns based upon the currently approved capital structure, not the imputed one based on the capital structure of the parent company.

Credit Metrics:

NI's leverage is high among its peer groups primarily as a result of the legacy debt associated with the acquisition of Columbia Energy Group in November 2000. Based on the preliminary assessment of management's business plan, Fitch projects NI's debt to Operating EBITDAR from 2016 to 2017 to average approximate 4.9 times (x) and FFO fixed charge cover to average 3.3x. These metrics could potentially improve to 4.4x and 3.5x respectively, by 2020. Fitch's projection considers the expiration of the bonus depreciation benefits and a reasonable amount of equity issuance to support the sizable capital spending which is approximately $1.2 billion annually. Typically NI's leverage peaks at the end of the year as a result of seasonal gas storage purchases at its gas utilities and drops during the following months as gas costs are recovered. These metrics are somewhat weak in 2016 and 2017 and will become stronger beginning 2018 for its rating category relative to its peers with a similar risk profile.

Strong Parent Sub Linkages:

NI and NIPSCO's ratings historically were and will continue to be closely linked due to the fact that NI finances majority of its operations through NIF with guarantee from NI. As of June 30, 2014, NIPSCO had $95.5 million of medium term notes and $226 million of pollution control bonds outstanding issued through Jasper Co. Indiana. Columbia Gas of Massachusetts (aka Bay State Gas) had $40 million of notes outstanding (not rated by Fitch). All NI subsidiaries currently share a revolver at NIF. The remaining entities after the separation are expected to continue to share a credit facility at NIF.

RATING SENSITIVITIES:

Positive: Future developments that may, individually or collectively, lead to a positive rating action include:

--Reduced regulatory risk with expanded revenue tracking mechanisms;

--Well capitalized balance sheet after the separation which contributes to improving credit metrics with expected sustained consolidated debt to Operating EBITDAR below 4.75x.

Negative: Future developments that may, individually or collectively, lead to a negative rating action include:

--Materially unfavorable regulatory decisions;

--Not issuing adequate equity to support the significant capital program resulting in sustained consolidated debt to Operating EBITDAR above 5.50x.

Fitch has affirmed the following ratings with a Stable Outlook:

NiSource Inc.

--IDR at 'BBB-'.

NiSource Finance Corp.

--Senior unsecured at 'BBB-';

--Commercial paper at 'F3.

NiSource Capital Markets

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FII Fitch Affirms NiSource at 'BBB-' on Spin-off Announcement
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--Senior unsecured at 'BBB-'.

Northern Indiana Public Service Co.

--IDR at 'BBB-';

--Senior unsecured and revenue bonds at 'BBB'.

Fitch has assigned the following rating with a Stable Outlook:

NiSource Inc.

--Short-term IDR at 'F3'.

Fitch has withdrawn the following IDRs, as these entities and their IDRs are no long considered analytically meaningful for the credit quality of the debt that have been issued out of them:

NiSource Finance Corp.

--IDR at 'BBB-';

--Short-term IDR at 'F3'.

NiSource Capital Markets

--IDR at 'BBB-'.

All debt issued by NiSource Finance Corp. and NiSource Capital Markets was fully guaranteed by NI, and the ratings of those issuances remain outstanding.

Contact:

Primary Analyst

Julie Jiang

Director

+1-212-908-0708

Fitch Ratings, Inc.

33 Whitehall St.

New York, NY 10004

Secondary Analyst

Ralph Pellecchia

Senior Director

+1-212-908-0586

Committee Chairperson

Mark Sadeghian

Senior Director

+1-312-368-2090

Media Relations: Brian Bertsch, New York, Tel: +1 212-908-0549, Email: brian.bertsch@fitchratings.com.

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FII Fitch Affirms NiSource at 'BBB-' on Spin-off Announcement
Sep 29 2014 14:44:55

Applicable Criteria and Related Research:

--'Corporate Rating Methodology' (Aug. 5, 2013);

--'Recovery Ratings and Notching Criteria for Utilities' (Nov. 13, 2013);

--'Parent and Subsidiary Rating Linkage' (Aug. 8, 2013);

--'Rating U.S. Utilities, Power and Gas Companies' (March 9, 2014).

Applicable Criteria and Related Research:

Corporate Rating Methodology - Including Short-Term Ratings and Parent and Subsidiary Linkage

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=749393

Recovery Ratings and Notching Criteria for Utilities

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=722085

Rating U.S. Utilities, Power and Gas Companies (Sector Credit Factors)

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=735155

Additional Disclosure

Solicitation Status

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Research Update:

NiSource Inc. And Subsidiaries 'BBB-' Credit Ratings On Watch Positive On Potential Spin-Off Of Columbia Pipeline Group

Primary Credit Analyst:
Gerrit W Jepsen, CFA, New York (1) 212-438-2529; gerrit.jepsen@standardandpoors.com

Secondary Contacts:
Matthew L O'Neill, New York (1) 212-438-4295; matthew.oneill@standardandpoors.com
Nora Pickens, New York (1) 212-438-2257; nora.pickens@standardandpoors.com

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Research Update:

NiSource Inc. And Subsidiaries 'BBB-' Credit Ratings On Watch Positive On Potential Spin-Off Of Columbia Pipeline Group

Overview

- NiSource Inc. announced that it intends to spin off its pipeline and midstream energy business, Columbia Pipeline Group (CPG).
- We are placing our 'BBB-' issuer credit ratings (ICR) and issue ratings on NiSource and utility subsidiaries Northern Indiana Public Service Co., Bay State Gas Co., as well as finance entities NiSource Finance Corp. and NiSource Capital Markets Inc. on CreditWatch with positive implications. We based the CreditWatch placement on the expected improvement in NiSource's business risk profile after the spin-off of CPG and sufficient credit measures that could result in an upgrade.
- Based on the transaction's preliminary terms, we could raise the ICRs on NiSource and its subsidiaries by up to two notches, subject to the spin-off execution and recapitalization of the remaining NiSource businesses. Operating results would also have to remain in line with our expectations.
- We also placed our 'A-3' short-term ratings on NiSource and NiSource Finance on CreditWatch with positive implications.

Rating Action

On Sept. 29, 2014, Standard & Poor's Ratings Services placed its 'BBB-' issuer credit ratings and issue ratings on NiSource Inc. and utility subsidiaries Northern Indiana Public Service Co. (NIPSCO), Bay State Gas Co., as well as finance entities NiSource Finance Corp. and NiSource Capital Markets Inc. on CreditWatch with positive implications. At the same time, we placed our 'A-3' short-term ratings on NiSource and NiSource Finance on CreditWatch with positive implications.

Rationale

Our CreditWatch placement reflects our expectation that NiSource's credit profile will strengthen after the spin-off of the pipeline and midstream energy business, Columbia Pipeline Group (CPG). Following this divestiture, NiSource's pro forma operating earnings would be about two-thirds low-risk regulated natural gas distribution utility operations and one-third vertically integrated electric utility operations. NiSource's current business risk profile is "strong" and with the divestiture of the higher risk midstream energy assets, NiSource's business risk profile would be revised to

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"excellent." The "excellent" business risk assessment would incorporate NiSource's focus only on regulated utility operations where there is geographical and operating diversity with numerous utilities that serve more than 3.3 million natural gas distribution customers in seven states from Indiana to Massachusetts and 450,000 electricity customers in northern Indiana.

We consider the company's gas distribution operations to be above average, characterized by ample geographic diversity and integration with NiSource's existing gas transmission network, which provides operational flexibility. Nearly all of the gas distribution subsidiaries' needs are contracted with Columbia Transmission and the distribution companies' use gas in storage for roughly 70% of peak gas needs. This bolsters service reliability, thereby supporting the business risk profile. Cash flow variability is also low given material revenue stabilization and cost-tracking mechanisms. NIPSCO is a vertically integrated electric and natural gas utility providing service mostly in Northern Indiana. Customer growth has been flat and industrial exposure has been above average, largely due to the steel-related industry. The utility has been installing environmental compliance equipment and using an environmental rate surcharge for timely cost recovery. Rates are above the state average, but not the highest in Indiana.

Based on our medial volatility financial ratio benchmarks, NiSource's current financial risk profile is "significant." Upon the divestiture of CPG, we expect to assess NiSource's financial risk profile as "aggressive" based on our baseline forecast, which assumes that funds from operations (FFO) to debt will range from 12% and 13% over the three years following the spin-off. We also expect cash flow from operations to debt to range between 12% and 13% over the same period. We forecast debt to EBITDA to range between 5.1x and 5.3x. The annual dividend payout ratio is forecast to average 65% over the three-year period. This level should bolster equity capital through retained earnings, helping to support the balance sheet while NiSource makes capital investments., Because of this large capital spending program, we expect that discretionary cash flow will continue to be materially negative, resulting in external funding needs.

Liquidity

NiSource currently has "adequate" liquidity, as our criteria define the term. The company's liquidity sources are likely to cover its uses by more than 1.1x in the next 12 months. We expect NiSource to meet cash outflows even with a 10% decline in EBITDA.

There are sizable debt maturities in 2016, but we expect the company to refinance them given its satisfactory standing in the credit markets.

Principal liquidity sources:

- FFO of about $1.3 billion in 2014
- Credit facility availability of about $1.3 billion in 2014

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Principal liquidity uses:

- Debt maturities of about $540 million in 2014
- Maintenance capital spending of $1.1 billion in 2014
- Dividends of roughly $320 million in 2014

Other modifiers

The ratings on NiSource reflect our application of a one-notch negative adjustment for our "comparable rating analysis" modifier. This adjustment accounts for the company's weak financial measures within the "significant" financial risk profile. Our determination that projected credit protection measures are expected to be mostly near the upper end of the "aggressive" category after divesting the midstream business could also result in our application of the comparable rating analysis modifier, but with one-notch positive adjustment in the stand alone credit profile and rating.

Group influence

We base the ICR on NiSource on the consolidated group credit profile (GCP) and application of our group ratings methodology. NiSource, as the parent company, currently has an ICR equal to the 'bbb-' GCP, which we will reassess as part of the CreditWatch resolution. Under our group rating methodology, we consider all of NiSource's regulated utilities and finance entities core subsidiaries of the NiSource group because we believe the utilities are integral to NiSource's long-term strategy. The ICRs for these subsidiaries are therefore most likely to remain equal to the GCP established for NiSource.

CreditWatch

The CreditWatch placement will remain until the transaction's closing appears certain, with updates as needed. We could subsequently raise the issuer credit ratings and issue ratings on NiSource, NIPSCO, Bay State Gas, NiSource Finance, and NiSource Capital Markets by up to two notches depending on the proposed financing and resulting credit measures of the remaining consolidated NiSource group. The ultimate rating would depend on any changes to our base case forecast and cash flow generation capability of the pro forma group.

Related Criteria And Research

- Criteria - Corporates - General: Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Jan. 2, 2014
- Key Credit Factors For The Midstream Energy Industry, Dec. 19, 2013
- Country Risk Assessment Methodology And Assumptions, Nov. 19, 2013
- Criteria - Corporates - Utilities: Key Credit Factors For The Regulated Utilities Industry, Nov. 19, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- General Criteria: Methodology: Industry Risk, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology: Ratios And

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Adjustments, Nov. 19, 2013
- Methodology For Linking Short-Term And Long-Term Ratings For Corporate, Insurance, And Sovereign Issuers, May 7, 2013
- General Criteria: Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- General Criteria: Stand-Alone Credit Profiles: One Component Of A Rating, Oct. 1, 2010
- Criteria - Corporates - Utilities: Notching Of U.S. Investment-Grade Investor-Owned Utility Unsecured Debt Now Better Reflects Anticipated Absolute Recovery, Nov. 10, 2008
- 2008 Corporate Criteria: Rating Each Issue, April 15, 2008
- Criteria - Corporates - General: 2008 Corporate Criteria: Commercial Paper , April 15, 2008

Ratings List

Ratings Affirmed; On CreditWatch Positive

	To	From
NiSource Inc.		
Corporate Credit Rating	BBB-/Watch Pos/A-3	BBB-/Stable/A-3
NiSource Finance Corp.		
Corporate Credit Rating	BBB-/Watch Pos/A-3	BBB-/Stable/A-3
Senior Unsecured	BBB-/Watch Pos	BBB-
Commercial paper	A-3/Watch Pos	A-3
NiSource Capital Markets Inc.		
Corporate Credit Rating	BBB-/Watch Pos/--	BBB-/Stable/--
Senior Unsecured	BBB-/Watch Pos	BBB-
Northern Indiana Public Service Co.		
Corporate Credit Rating	BBB-/Watch Pos/--	BBB-/Stable/--
Senior Unsecured	BBB-/Watch Pos	BBB-
Bay State Gas Co.		
Corporate Credit Rating	BBB-/Watch Pos/--	BBB-/Stable/--
Senior Unsecured	BBB-/Watch Pos	BBB-

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MOODY'S
INVESTORS SERVICE

Credit Opinion: NiSource Inc.

Global Credit Research - 14 Oct 2014

Merrillville, Indiana (State of), United States

Ratings

Category	**Moody's Rating**
Outlook	Stable
Pref. Shelf	(P)Ba1
NiSource Finance Corporation	
Outlook	Stable
Issuer Rating	Baa2
Bkd Sr Unsec Bank Credit Facility	Baa2
Senior Unsecured	Baa2
Bkd Commercial Paper	P-2
NiSource Capital Markets, Inc.	
Outlook	Stable
Bkd Senior Unsecured	Baa2
Northern Indiana Public Service Company	
Outlook	Stable
Issuer Rating	Baa1
Senior Unsecured	Baa1
Bay State Gas Company	
Outlook	Stable
Senior Unsecured	Baa2

Contacts

Analyst	**Phone**
Lesley Ritter/New York City	212.553.1607
William L. Hess/New York City	212.553.3837

Key Indicators

[1]**NiSource Inc.**

	6/30/2014(L)	12/31/2013	12/31/2012	12/31/2011	12/31/2010
CFO pre-WC + Interest / Interest	4.1x	4.0x	4.2x	3.8x	3.9x
CFO pre-WC / Debt	14.6%	14.7%	16.2%	13.7%	15.7%
CFO pre-WC - Dividends / Debt	11.5%	11.4%	13.2%	10.7%	12.6%
Debt / Capitalization	51.0%	50.7%	51.5%	53.7%	53.6%

[1] All ratios are based on 'Adjusted' financial data and incorporate Moody's Global Standard Adjustments for Non-Financial Corporations. Source: Moody's Financial Metrics

Note: For definitions of Moody's most common ratio terms please see the accompanying User's Guide.

Opinion

Rating Drivers

- NiSource set to become a fully regulated utility company post mid-2015 corporate separation
- Regulated utility assets are low risk, a material credit positive
- Persistent high debt balance and elevated investment spend weigh on financial profile
- MLP formation credit impact negligible given planned spin-off of pipeline segment

Corporate Profile

NiSource Inc. (Baa2 senior unsecured for its guaranteed financing vehicle) is a holding company with regulated local natural gas distribution company (LDC) subsidiaries in Ohio, Pennsylvania, Virginia, Massachusetts, Kentucky and Maryland, a combination vertically integrated electric and gas utility in Indiana, and an interstate natural gas pipeline and storage system that runs from the Gulf Coast to the Northeast. The company maintains operations in three segments: natural gas distribution (39% of 2013 operating income), electric generation, transmission and distribution (23% of 2013 operating income), and natural gas pipelines and storage (38% of 2013 operating income). While the company has one of the largest LDC, natural gas pipeline, and gas storage systems in the US, its vertically integrated electric utility is mid-sized. Two of NiSource's utility subsidiaries are rated: Bay State Gas Company (Bay State, doing business as Columbia Gas of Massachusetts, Baa2 senior unsecured, stable) and Northern Indiana Public Service Company (NIPSCO, Baa1 senior unsecured, stable).

On 28 September 2014, NiSource announced its plan to separate into two publicly traded companies by mid-2015. The companies will consist of NiSource Inc.: a holding company with a portfolio of fully regulated electric and natural gas utility subsidiaries, and Columbia Pipeline Group (CPG): a pure play natural gas pipeline, midstream and storage business. Contemporaneously, NiSource announced the formation of a Master Limited Partnership (MLP) to be used as a funding vehicle for CPG's extensive investment inventory. The MLP will remain with CPG post separation.

On 29 September 2014, we affirmed the Baa2 senior unsecured rating for NiSource's guaranteed financing vehicle. The outlook is stable.

SUMMARY RATING RATIONALE

NiSource's Baa2 rating reflects the credit supportiveness and diversity of its multiple regulatory jurisdictions, the low business risk nature of its operations (approximately 65% of utility operating earnings is represented by natural gas LDCs), as well as its broad geographical footprint and scale (approximately 4 million utility customers across seven states). Together, these help mitigate against the anticipated weakening of its financial profile as the company manages elevated debt levels while executing on a sizeable capital investment program. We anticipate a ratio of cash flow to debt in the low-teen's range over the next three to five years.

DETAILED RATING CONSIDERATIONS

NISOURCE TO BECOME A FULLY REGULATED UTILITY COMPANY POST 2015 CORPORATE SEPARATION

The spin-off of CPG into a separate, publicly listed company, simplifies NiSource's operations and transforms the company into a fully regulated utility. It also removes the uncertainty associated with its pipeline business including contract renewal risk and execution risk on its multibillion dollar capital expenditure program. Furthermore, given the creation of an MLP to finance CPG's capital investments, the separation allows NiSource to maintain a straightforward and transparent corporate financing structure.

REGULATED UTILITY ASSETS ARE LOW RISK, A MATERIAL CREDIT POSITIVE

Upon corporate separation, expected in mid-2015, NiSource's seven LDCs will represent about 65% of pro forma operating income, while its vertically integrated electric utility segment will make up the difference.

NiSource's LDCs have become steadier and more profitable over the past several years due to rate increases and improved rate design. Since 2007, a round of rate cases across all jurisdictions has brought rate relief that has increased this segment's operating income by 37%, and raised the LDCs' consolidated non-volumetric revenue recovery to above 80%. NiSource's electric segment is nearing completion of its major environmental project, and

its generation fleet will be fully MATS compliant by 2015.

The state regulators overseeing NiSource's utilities are generally credit supportive. Each LDC benefits from decoupling mechanisms and/or weather normalization adjustments which reduce earnings volatility. In addition, NiSource has access to a variety of tracker mechanisms across its different jurisdictions to cover its ongoing infrastructure replacement program, that provide for timely recovery of its sizeable infrastructure investment program. Similarly, NiSource's electric segment benefits from a broad array of tracker mechanisms providing for timely recovery of operating expenses as well as environmental and system modernization investments.

In 2014, NiSource completed a single general rate case and filed for new base rates in Pennsylvania and Virginia. Columbia Gas of Massachusetts' (CMA, 7% of consolidated utility rate base) rate case was decided following a fully litigated proceeding with a final order granting about 65% of CMA's requested increase based on a 9.55% return on equity and a 53.68% equity ratio.

Massachusetts continues to be NiSource's most challenging jurisdictions where rate cases are typically fully litigated rather than settled. Nevertheless, we view CMA's latest rate case order as generally credit positive since it granted the company a return on equity that is higher than the one allowed in its 2012 rate order, an equity strong capital structure, as well as the right to continue the company's targeted infrastructure recovery factor, which provides for recovery of its pipeline replacement program.

NiSource's two ongoing base rate proceedings together account for 20% of consolidated utility rate base and, if approved as filed, would represent a total of $86 million in additional annual revenues with partial new rates going into effect as of 1 October 2014.

Among its other 2014 regulatory proceedings, NiSource received regulatory approvals on its seven-year electric and gas investment plans filed in Indiana for a total investment amount of $1.8 billion. The legislation provides for cost recovery outside of a base rate proceeding for new or replacement electric and gas transmission, distribution and storage projects, with 80% of eligible costs being recovered using the TDSIC rider and 20% of the costs being deferred. We expect TDSIC along with NiSource's other infrastructure riders to allow the company to stay out of general rate case proceedings for a number of years. This provides significant earnings visibility for NiSource's utilities and allows for predictable operating cash flow generation over the near to medium term, a credit positive.

PERSISTENT HIGH DEBT BALANCE AND ELEVATED INVESTMENT SPEND WEIGH ON FINANCIAL PROFILE

NiSource's rating is constrained by its weak financial profile, primarily relating to its elevated debt levels which appear to be permanent. The extensive capital investment projects at its utilities, estimated at about $1.2 billion per year (or 2.7x 2013 depreciation) through 2020, will keep some pressure on the company's financial profile for the foreseeable future. We anticipate that its debt coverage metrics will decline from their current mid-teen levels over the next few years, falling to the 11-12% range before returning to 13-14% once new projects begin generating sufficient cash flows to offset the company's elevated debt balance. Furthermore, given NiSource's existing leverage position, we expect the company will apply a conservative approach to its capital investments funding, including equity issuances, as necessary.

MLP FORMATION CREDIT IMPACT NEGLIGIBLE GIVEN PLANNED CPG SPIN-OFF

With $12-15 billion in capital investments planned at CPG over the next 10 years, NiSource is creating a new MLP, Columbia Pipeline Partners (CPP, not rated), to fund the equity portion of its spend. The credit impact of the MLP formation on NiSource's rating is negligible given the expectation that CPP will be spun off by mid-2015 when NiSource's corporate separation is completed.

Notching Considerations

NiSource's operating subsidiary NIPSCO is rated one notch above NiSource to reflect its default probability and the structural seniority of its debt to substantially all the parent guaranteed debt at NiSource Finance Corp. Bay State's debt is guaranteed by NiSource and has the same rating as NiSource.

As shown in the methodology grid below, the grid indicates a rating of Baa1, which does not reflect the structural subordination that causes the actual parent rating to be Baa2. Ratings within the NiSource family are notched closely, because of the company's practice to centrally manage its subsidiaries' cash flow in a corporate money pool and consolidating its debt financing at its guaranteed financing subsidiary NiSource Finance Corp.

Liquidity Profile

NiSource's liquidity is adequate. NiSource maintains a $2.0 billion revolving credit facility due September 2018. The revolver backs its $1.5 billion commercial paper program and provides funds for ongoing working capital needs. Terms of the facility allow for reliable access to funds by not requiring the company to represent and warrant to any material adverse change at each borrowing. The sole financial covenant is a debt-to-capitalization ratio of 70% which the company satisfied as of 30 June 2014, with a debt to cap ratio of 60.6%.

NiSource also maintains three separate accounts receivable securitization programs totaling $515 million at its LDCs ($300 million outstanding as of 30 June 2014). The programs are renewed annually.

As of 30 June 2014, NiSource had $18 million of cash on hand in addition to $1.2 billion of available capacity under its revolver after giving effect to $801 million of commercial paper and $14 million in letters-of-credit outstanding. NiSource has $230 million of notes due in November 2015, a $325 million term loan due April 2016, and another $422 million of notes due in 2016.

Rating Outlook

The stable outlook reflects our expectation that NiSource's financial profile will decline modestly due to its planned corporate separation, but only temporarily. A debt to capitalization ratio of approximately 50% is expected as well as a decline in its cash flow to debt to the 11% - 12% range before slowly rising closer to the low-teens range. The stable outlook reflects and anticipates a smooth corporate separation, and incorporates a view that NiSource's regulated utility capital expenditure plans will be financed with a balanced mix of debt and equity. The outlook also takes into account the credit supportiveness of NiSource's regulatory environments, the low business risk associated with its LDC operations, and the scale and scope of its footprint, which together mitigate metrics that are weak for the rating category.

What Could Change the Rating - Up

An upgrade could be considered if there was further improvement in the utility's regulatory environment or if cash flow to debt rises to the high teens and interest coverage exceeds 4.0x on a sustained basis.

What Could Change the Rating - Down

The rating could be downgraded if there is a decline in credit supportiveness of NiSource's regulatory environments, an adverse change in the company's business mix or corporate structure such that its business risk profile deteriorates, or if debt coverage and interest coverage fall below 12% or 3.0x, respectively, on a sustained basis.

Rating Factors

NiSource Inc.

Regulated Electric and Gas Utilities Industry Grid [1][2]	Current LTM 6/30/2014		[3]Moody's 12-18 Month Forward ViewAs of October 2014	
Factor 1 : Regulatory Framework (25%)	**Measure**	**Score**	**Measure**	**Score**
a) Legislative and Judicial Underpinnings of the Regulatory Framework	A	A	A	A
b) Consistency and Predictability of Regulation	A	A	A	A
Factor 2 : Ability to Recover Costs and Earn Returns (25%)				
a) Timeliness of Recovery of Operating and Capital Costs	A	A	A	A
b) Sufficiency of Rates and Returns	A	A	A	A
Factor 3 : Diversification (10%)				
a) Market Position	A	A	A	A
b) Generation and Fuel Diversity	Ba	Ba	Ba	Ba
Factor 4 : Financial Strength (40%)				
a) CFO pre-WC + Interest / Interest (3 Year	4.0x	Baa	3x - 4x	Baa

Avg)				
b) CFO pre-WC / Debt (3 Year Avg)	15.0%	Baa	11% - 14%	Baa
c) CFO pre-WC - Dividends / Debt (3 Year Avg)	11.9%	Baa	9% - 12%	Baa
d) Debt / Capitalization (3 Year Avg)	51.4%	Baa	49% - 53%	Baa
Rating:				
Grid-Indicated Rating Before Notching Adjustment		Baa1		Baa1
HoldCo Structural Subordination Notching	0	0	0	0
a) Indicated Rating from Grid		Baa1		Baa1
b) Actual Rating Assigned		Baa2		Baa2

[1] All ratios are based on 'Adjusted' financial data and incorporate Moody's Global Standard Adjustments for Non-Financial Corporations. [2] As of 6/30/2014(L); Source: Moody's Financial Metrics [3] This represents Moody's forward view; not the view of the issuer; and unless noted in the text, does not incorporate significant acquisitions and divestitures.

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NiSource Inc.

Primary Credit Analyst:
Gerrit W Jepsen, CFA, New York (1) 212-438-2529; gerrit.jepsen@standardandpoors.com

Secondary Contact:
Matthew L O'Neill, New York (1) 212-438-4295; matthew.oneill@standardandpoors.com

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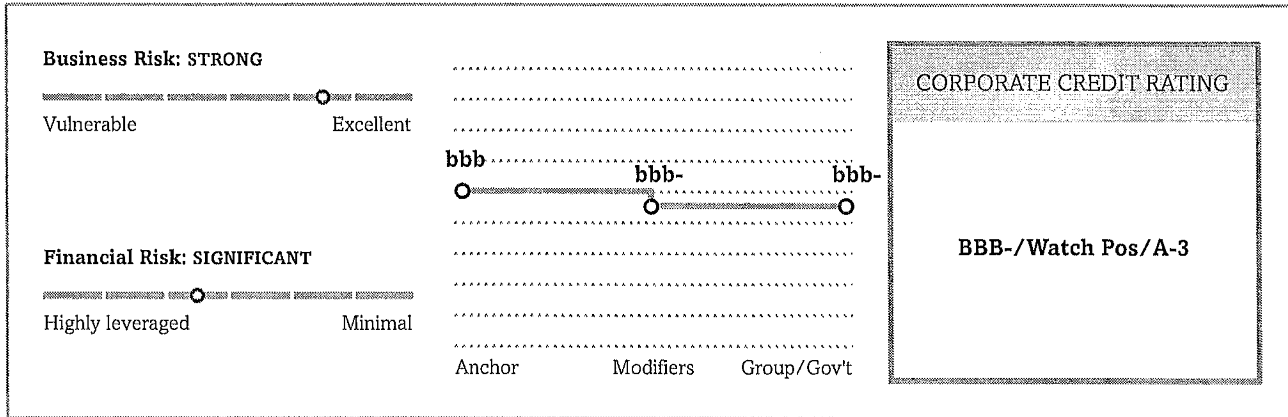
NiSource Inc.



Rationale

Business Risk: Strong	Financial Risk: Significant
• Corporate strategy based on regulated utilities and soon-to-be-divested energy midstream business Columbia Pipeline Group (CPG) • Regulated utilities with mostly low operating risks • Lack of competition in regulated service territories • Diverse service area in seven states with numerous regulatory jurisdictions and a large residential customer base • Gas distribution operations with geographic diversity and integration with the company's gas transmission network, providing operational flexibility • Electric utility subsidiary Northern Indiana Public Service Co.'s (NIPSCO) higher-than-average dependence on industrial customers and flat growth at the utility	• Expected high debt leverage (debt to EBITDA) of more than 5x • Cash flow to debt measures, albeit improving slightly, are toward the lower end of the "significant" financial risk profile • High capital spending • Continuing high dividends • Negative discretionary cash flow

CreditWatch

The ratings will remain on CreditWatch with positive implications until the spin-off of NiSource Inc.'s pipeline and midstream energy business, Columbia Pipeline Group, appears certain, with updates as needed. We could subsequently raise the issuer credit ratings and issue ratings on NiSource, NIPSCO, Bay State Gas, NiSource Finance, and NiSource Capital Markets by up to two notches, depending on the proposed financing and resulting credit measures of the remaining consolidated NiSource group. The ultimate rating would depend on any changes to our

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base case forecast and cash flow generation capability of the pro forma group.

Standard & Poor's Base-Case Scenario

Assumptions

- Spin-off of the midstream operations under CPG resulting in removal of midstream assets and its corresponding debt.
- Single-digit annual revenue growth over the next few years
- We expect capital spending of between $1.25 billion and $1.5 billion over next three years.
- Dividends in excess of $200 million over the forecast term
- Moderate rate increase in 2017 and 2018, which will allow it to earn close to its allowed returns on equity (ROEs).
- Continuation of current regulatory mechanisms.

Key Metrics

	2015E	2016E	2017E
FFO/debt (%)	12-14	12-14	13-14
OCF/debt (%)	12.5-13.5	13.5-15.0	14-16
Debt/EBITDA (x)	5-5.5	5-5.5	5-5.5

Standard & Poor's adjusted figures. E--Estimate. FFO--Funds from operations. OCF--Operating cash flow.

Company Description

NiSource Inc. is an energy holding company engaged in natural gas transmission, storage, and distribution, as well as electric generation, transmission, and distribution, serving more than 3.3 million and about 455,000 customers in its gas and electric distribution businesses, respectively, in seven states. NIPSCO, Bay State Gas, and Columbia Gas are pure-play utilities while CPG is involved in midstream operations. NiSource Finance Corp. and NiSource Capital Markets Inc. are the financing entities for NiSource Inc.

Business Risk: Strong

We based our assessment of NiSource's business risk profile on the company's "satisfactory" competitive profile and "very low" industry risk mostly derived from the regulated utility industry and the "very low" country risk of the U.S. where the company operates.

NiSource's competitive position partly reflects the stable regulatory framework of the low-risk regulated utility operations. We consider the company's gas distribution operations to be above average, characterized by ample geographic diversity and integration with the company's gas transmission network, which provides operational flexibility. Nearly all of the gas distribution subsidiaries' needs are contracted with Columbia Transmission, with roughly 70% of peak gas needs met with storage gas. This bolsters service reliability, thereby supporting the business risk profile. Cash flow variability is also low given material revenue stabilization and cost-tracking mechanisms. NIPSCO is a vertically integrated electric and natural gas utility providing service mostly in northern Indiana. It has flat

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customer growth and above-average industrial exposure, largely to the steel-related industry. The utility has been installing environmental compliance equipment and using an environmental rate surcharge for timely recovery of costs. Base rates and various rate surcharges support cost recovery. Rates are above the state average, but not the highest in Indiana.

NiSource's current competitive position also reflects the gas midstream businesses, including a gas transmission network that has a huge underground storage system (working gas of about 280 billion cubic feet) and access to multiple supply basins. The company derives slightly more than 90% of revenues from firm take-or-pay contracts, and a moderate contract life exists mainly at maximum rates. These contracts provide more cash flow certainty because gas shippers pay whether or not they have gas to be transported. However, the company intends to spin-off these riskier midstream operations by mid-2015, after which we would incorporate such changes into company's business mix in our assessment.

S&P Base-Case Operating Scenario

- Spin-off of the riskier midstream operations under CPG, resulting in the removal of midstream assets and its corresponding debt, which would improve the company's business risk profile.
- The economic conditions in the company's service territories are either holding steady or improving, which will likely increase customer usage.
- Base EBITDA is forecast to grow from customer growth, volume-related growth, moderate rate increases, and expansion projects that are expected to come into service over the forecast period.
- Utilities operate under regulatory terms that largely support credit quality and are generally constructive, which includes good gas adjustment and other cost-pass-through mechanisms. These provide for timely recovery of costs that helps support steady revenues.
- NIPSCO continues spending on new transmission projects and pollution-control equipment while seeking higher operating cash flow through base rates and various rate surcharges. After starting rate recovery of these investments, we forecast that revenue and EBITDA will grow beyond base levels.

Peer comparison

Table 1

NiSource Inc.--Peer Comparison

Industry sector: combo

	NiSource Inc.	Dominion Resources Inc.	AGL Resources Inc.	DTE Energy Co.	Great Plains Energy Inc.
Rating as of March 24, 2015	BBB-/Watch Pos/A-3	A-/Negative/A-2	BBB+/Stable/A-2	BBB+/Positive/A-2	BBB+/Stable/A-2
	--Average of past three fiscal years--				
(Mil. $)					
Revenues	5,729.7	12,883.0	4,641.3	10,043.6	2,441.5
EBITDA	1,828.9	4,860.2	1,294.8	2,505.4	1,013.5
Funds from operations (FFO)	1,388.7	3,680.5	956.9	1,773.3	756.3
Operating income	1,127.5	3,201.8	832.9	1,486.1	631.9

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Table 1

NiSource Inc.--Peer Comparison (cont.)					
EBIT	1,181.8	3,447.8	851.3	1,616.1	634.4
Interest Expense	479.4	1,169.4	223.1	601.5	260.8
Net income from cont. oper.	477.4	1,141.0	382.0	746.3	231.0
Working capital changes	(16.6)	(163.3)	(31.0)	46.3	12.3
Cash flow from operations	1,361.6	3,674.9	877.2	1,968.2	724.4
Capital expenditures	1,793.1	4,514.4	755.0	1,888.3	692.1
Free operating cash flow	(431.5)	(839.6)	122.2	79.9	32.3
Dividends paid	300.1	1,357.9	235.3	455.0	135.3
Discretionary cash flow	(731.6)	(2,197.4)	(113.1)	(375.1)	(103.1)
Cash and short-term investments	5.3	47.0	28.7	9.8	1.8
Debt	9,456.1	22,568.6	4,773.2	9,532.4	4,513.9
Preferred stock	0.0	1,882.8	0.0	240.0	19.5
Equity	5,872.1	13,343.7	3,646.3	8,227.5	3,486.3
Debt and equity	15,328.2	35,912.3	8,419.5	17,759.9	8,000.2
Adjusted ratios					
Compound annual revenue growth (%)	2.4	(4.7)	32.1	11.6	3.5
EBITDA margin (%)	31.9	37.7	27.9	24.9	41.5
EBIT interest coverage (x)	2.5	2.9	3.8	2.7	2.4
Return on capital (%)	6.6	8.3	8.5	7.8	7.1
EBITDA interest coverage (x)	3.8	4.2	5.8	4.2	3.9
EBITDA cash int. cov. (x)	4.4	5.0	6.8	5.6	4.9
FFO cash int. cov. (X)	4.5	5.0	6.2	5.3	4.9
CFO cash int. cov. (x)	3.3	3.8	4.6	4.4	3.5
Debt/EBITDA (x)	5.2	4.6	3.7	3.8	4.5
FFO/debt (%)	14.7	16.3	20.0	18.6	16.8
Cash flow from operations/debt (%)	14.4	16.3	18.4	20.6	16.0
Free operating cash flow/debt (%)	(4.6)	(3.7)	2.6	0.8	0.7
Discretionary cash flow/debt (%)	(7.7)	(9.7)	(2.4)	(3.9)	(2.3)
Total debt/debt plus equity (%)	61.7	62.8	56.7	53.7	56.4

Financial Risk: Significant

Based on the Medial Volatility financial ratio benchmarks, our assessment of NiSource's financial risk profile is significant. This takes into consideration the removal of midstream assets and the corresponding debt after the CPG spin-off, sustained cash flows from the regulated utility operations, and moderate rate increases in 2017 and 2018 that will allow it to earn close to its allowed ROEs. Also, we based the designation on the company's aggressive capital

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spending program and a dividend payout that exceeds 50%. We expect NiSource to continue having negative free operating cash flow over the next three years. Although we expect equity to grow, we also expect the company to continue using debt financing.

For the 12 months ended Dec. 31, 2014, adjusted FFO to debt was 13.7% and operating cash flow to debt was 13.1%. Our baseline forecast includes financial measures plateauing, with FFO to debt ranging between 12.5% and 14% over the next three years and operating cash flow to debt ranging from 13% to 15.5% over the same period. The plateauing financial measures include the effects of volume growth coupled with cost recovery through riders offset by moderate operations and maintenance increase.

S&P Base-Case Cash Flow And Capital Structure Scenario

- NiSource's cash flow ratios will remain consistent with the significant financial risk profile in 2014 and 2015. This includes an FFO to debt ratio ranging from roughly 12.5% to 14% and operating cash flow to debt ranging from 13% to 15.5%.
- Cash flow after capital spending and dividends, discretionary cash flow, will be negative over the next three years, resulting in external funding needs.
- Debt leverage as indicated by debt to EBITDA expected to remain above 5x each year over the next three years.

Financial summary

Table 2

NiSource Inc. -- Financial Summary

Industry sector: combo

	--Fiscal year ended Dec. 31--				
	2014	**2013**	**2012**	**2011**	**2010**
Rating history	BBB-/Watch Pos/A-3	BBB-/Stable/A-3	BBB-/Stable/A-3	BBB-/Stable/A-3	BBB-/Stable/--
(Mil. $)					
Revenues	6,470.6	5,657.3	5,061.2	6,019.1	6,422.0
EBITDA	1,904.8	1,838.7	1,743.3	1,572.2	1,667.4
Funds from operations (FFO)	1,400.6	1,394.4	1,371.1	1,036.2	1,222.2
Operating income	1,160.1	1,153.5	1,068.9	945.5	998.8
EBIT	1,229.0	1,213.6	1,102.8	952.8	1,017.6
Interest Expense	486.9	469.1	482.3	431.4	475.1
Net income from continuing operations	530.7	490.9	410.6	303.8	294.6
Cash flow from operations	1,362.8	1,460.1	1,261.9	1,184.8	1,066.4
Capital expenditures	2,020.5	1,867.1	1,491.7	1,122.1	801.1
Free operating cash flow	(657.7)	(407.0)	(229.8)	62.7	265.3
Dividends paid	321.3	305.9	273.2	257.8	255.6
Discretionary cash flow	(979.0)	(712.9)	(503.0)	(195.1)	9.7
Cash and short-term investments	0.0	6.7	9.1	2.9	2.3
Debt	10,415.2	9,108.4	8,844.7	8,463.4	8,055.8
Preferred stock	0.0	0.0	0.0	0.0	0.0

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Table 2

NiSource Inc. -- Financial Summary (cont.)					
Equity	6,175.3	5,886.6	5,554.3	5,011.5	4,982.8
Debt and equity	16,590.5	14,995.0	14,399.0	13,475.0	13,038.6
Adjusted ratios					
EBITDA margin (%)	29.4	32.5	34.4	26.1	26.0
EBIT margin(%)	19.0	21.5	21.8	15.8	15.8
EBITDA interest coverage (x)	3.9	3.9	3.6	3.6	3.5
EBITDA cash int. cov. (x)	4.4	4.4	4.4	4.2	4.2
FFO cash int. cov. (x)	4.3	4.5	4.7	3.9	4.3
CFO cash int. cov. (x)	3.1	3.5	3.2	3.2	2.7
Debt/EBITDA (x)	5.5	5.0	5.1	5.4	4.8
FFO/debt (%)	13.4	15.3	15.5	12.2	15.2
Cash flow from operations/debt (%)	13.1	16.0	14.3	14.0	13.2
Free operating cash flow/debt (%)	(6.3)	(4.5)	(2.6)	0.7	3.3
Discretionary cash flow/debt (%)	(9.4)	(7.8)	(5.7)	(2.3)	0.1
Net Cash Flow / Capex (%)	53.4	58.3	73.6	69.4	120.7
Debt/debt and equity (%)	62.8	60.7	61.4	62.8	61.8
Return on capital (%)	6.4	6.8	6.6	6.1	6.7
Return on common equity (%)	8.7	8.4	7.6	6.1	6.0
Common dividend payout ratio (un-adj.) (%)	60.6	62.3	66.6	85.0	86.8

Liquidity: Adequate

NiSource has "adequate" liquidity, as our criteria define the term. The company's sources of liquidity are likely to cover its uses by more than 1.1x in the next 12 months. We expect NiSource to meet cash outflows even with a 10% decline in EBITDA. As such, Nisource benefits from stable cash flow generation, availability under its revolving credit facility and access to capital markets. There are sizable debt maturities in 2015 and 2016; however, we expect the company to refinance these given its satisfactory standing in the credit markets.

Principal Liquidity Sources	Principal Liquidity Uses
• We forecast FFO of about $1.1 billion in 2015 • Average availability of about $1.5 billion under the credit facility after the spin-off • Assets divestment of roughly $4 billion in 2015 • Common equity issuance of $1.2 billion in 2015	• Capital spending of about $1.6 billion in 2015 • Dividends of roughly $200 million in 2015 • Debt maturities of about $265 million in 2015 • Working capital outflows of about $120 million in 2015

Debt maturities

- 2015: $266.6 mil.
- 2016: $757.5 mil.
- 2017: $1350.3 mil.
- 2018: $811.1 mil.

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- 2019: $552.6 mil.

Covenant Analysis

NiSource's credit facility and three-year term loan have a covenant of maximum debt to total capital of 70%. As of year-end 2014, the ratio was 62%.

We believe headroom could erode somewhat if debt rises rapidly, without adequate growth in equity while the company makes capital investments.

Compliance Expectations	Requirements
• The company was in compliance as of Dec. 31, 2014 • Single-digit EBITDA growth and elevated capital spending should still permit a cushion • Covenant headroom could decrease without adequate cost recovery of capital investments	• Current: 70% • As of year-end 2015: 70% • As of year-end 2016: 70%

Other Credit Considerations

The ratings on NiSource include a one-notch negative adjustment for comparable rating analysis that reflects NiSource's weak financial ratios within the significant financial risk profile.

Group Influence

Under the group rating methodology, we view NiSource as the parent of the group whose members are NIPSCO, Bay State Gas, NiSource Finance, and NiSource Capital Markets. As a result, NiSource's group and stand-alone credit profiles are the same at 'bbb-'.

Ratings Score Snapshot

Corporate Credit Rating

BBB-/Watch Pos/A-3

Business risk: Strong

- **Country risk:** Very low
- **Industry risk:** Very low
- **Competitive position:** Satisfactory

Financial risk: Significant

- **Cash flow/Leverage:** Significant

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Anchor: bbb

Modifiers

- **Diversification/Portfolio effect:** Neutral (no impact)
- **Capital structure:** Neutral (no impact)
- **Financial policy:** Neutral (no impact)
- **Liquidity:** Adequate (no impact)
- **Management and governance:** Satisfactory (no impact)
- **Comparable rating analysis:** Negative (-1 notch)

Stand-alone credit profile : bbb-

- **Group credit profile:** bbb-

Recovery Analysis

NiSource has fully guaranteed the debt of Bay State Gas Co. and financing entity NiSource Finance, and mostly at finance entity NiSource Capital Markets. The short-term rating is 'A-3' based on the company's issuer credit rating (ICR) and our assessment of its liquidity as at least adequate. We rate the senior unsecured debt at NiSource Finance and NiSource Capital Markets the same as the ICR because priority obligations, including operating utility debt, are less than 20% of total assets.

Reconciliation

Table 3

Reconciliation Of NiSource Inc. Reported Amounts With Standard & Poor's Adjusted Amounts (Mil. $)

	--Fiscal year ended Dec. 31, 2014--									
NiSource Inc. reported amounts										
	Debt	Shareholders' equity	Revenues	EBITDA	Operating income	Interest expense	EBITDA	Cash flow from operations	Dividends paid	Capital expenditures
Reported	9,999.4	6,175.3	6,470.6	1,867.9	1,262.4	443.6	1,867.9	1,321.0	321.3	2,028.5
Standard & Poor's adjustments										
Interest expense (reported)	--	--	--	--	--	--	(443.6)	--	--	--
Interest income (reported)	--	--	--	--	--	--	3.8	--	--	--
Current tax expense (reported)	--	--	--	--	--	--	(11.3)	--	--	--
Operating leases	205.1	--	--	38.4	9.3	9.3	29.1	29.1	--	--
Postretirement benefit obligations/deferred compensation	436.9	--	--	(35.0)	(35.0)	24.5	(67.6)	15.1	--	--

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Table 3

Reconciliation Of NiSource Inc. Reported Amounts With Standard & Poor's Adjusted Amounts (Mil. $) (cont.)

Surplus cash	(25.4)	--	--	--	--	--	--	--	--	--
Capitalized interest	--	--	--	--	--	8.0	(8.0)	(8.0)	--	(8.0)
Share-based compensation expense	--	--	--	72.3	--	--	72.3	--	--	--
Dividends received from equity investments	--	--	--	37.8	--	--	37.8	--	--	--
Asset retirement obligations	103.6	--	--	1.5	1.5	1.5	(1.7)	5.6	--	--
Non-operating income (expense)	--	--	--	--	22.3	--	--	--	--	--
Debt - Accrued interest not included in reported debt	140.7	--	--	--	--	--	--	--	--	--
Debt - Other	(445.1)	--	--	--	--	--	--	--	--	--
EBITDA - Income (expense) of unconsolidated companies	--	--	--	(46.6)	(46.6)	--	(46.6)	--	--	--
EBITDA - Gain/(Loss) on disposals of PP&E	--	--	--	(31.5)	(31.5)	--	(31.5)	--	--	--
EBIT - Income (expense) of unconsolidated companies	--	--	--	--	46.6	--	--	--	--	--
Total adjustments	415.8	0.0	0.0	36.9	(33.4)	43.3	(467.3)	41.8	0.0	(8.0)

Standard & Poor's adjusted amounts

	Debt	Equity	Revenues	EBITDA	EBIT	Interest expense	Funds from operations	Cash flow from operations	Dividends paid	Capital expenditures
Adjusted	10,415.2	6,175.3	6,470.6	1,904.8	1,229.0	486.9	1,400.6	1,362.8	321.3	2,020.5

Related Criteria And Research

Related Criteria

- Criteria - Corporates - General: Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Dec. 16, 2014
- Criteria – Corporates - Industrials: Key Credit Factors For The Midstream Energy Industry, Dec. 19, 2013
- Criteria - Corporates - Utilities: Key Credit Factors For The Regulated Utilities Industry, Nov. 19, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- General Criteria: Methodology: Industry Risk, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- General Criteria: Methodology For Linking Short-Term And Long-Term Ratings For Corporate, Insurance, And Sovereign Issuers, May 7, 2013
- General Criteria: Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers,

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Nov. 13, 2012
- General Criteria: Stand-Alone Credit Profiles: One Component Of A Rating, Oct. 1, 2010
- Criteria - Corporates - Utilities: Notching Of U.S. Investment-Grade Investor-Owned Utility Unsecured Debt Now Better Reflects Anticipated Absolute Recovery, Nov. 10, 2008
- Criteria - Corporates - General: 2008 Corporate Criteria: Rating Each Issue, April 15, 2008
- Criteria - Corporates - General: 2008 Corporate Criteria: Commercial Paper, April 15, 2008

Business And Financial Risk Matrix

	Financial Risk Profile					
Business Risk Profile	Minimal	Modest	Intermediate	**Significant**	Aggressive	Highly leveraged
Excellent	aaa/aa+	aa	a+/a	a-	bbb	bbb-/bb+
Strong	aa/aa-	a+/a	a-/bbb+	**bbb**	bb+	bb
Satisfactory	a/a-	bbb+	bbb/bbb-	bbb-/bb+	bb	b+
Fair	bbb/bbb-	bbb-	bb+	bb	bb-	b
Weak	bb+	bb+	bb	bb-	b+	b/b-
Vulnerable	bb-	bb-	bb-/b+	b+	b	b-

Ratings Detail (As Of March 30, 2015)

NiSource Inc.	
Corporate Credit Rating	BBB-/Watch Pos/A-3
Commercial Paper	
Local Currency	A-3/Watch Pos
Senior Unsecured	BBB-/Watch Pos
Corporate Credit Ratings History	
29-Sep-2014	BBB-/Watch Pos/A-3
28-Jul-2011	BBB-/Stable/A-3
05-Mar-2009	BBB-/Stable/NR
Related Entities	
Bay State Gas Co.	
Issuer Credit Rating	BBB-/Watch Pos/NR
Senior Unsecured	BBB-/Watch Pos
NiSource Capital Markets Inc.	
Issuer Credit Rating	BBB-/Watch Pos/NR
Senior Unsecured	BBB-/Watch Pos
NiSource Finance Corp.	
Issuer Credit Rating	BBB-/Watch Pos/A-3
Northern Indiana Public Service Co.	
Issuer Credit Rating	BBB-/Watch Pos/NR
Senior Unsecured	AA-/Stable
Senior Unsecured	BBB-/Watch Pos

*Unless otherwise noted, all ratings in this report are global scale ratings. Standard & Poor's credit ratings on the global scale are comparable across countries. Standard & Poor's credit ratings on a national scale are relative to obligors or obligations within that specific country. Issue and debt ratings could include debt guaranteed by another entity, and rated debt that an entity guarantees.

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11 MAY 2015

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RATINGS

NiSource Finance Corporation*	
Issuer Rating	Baa2
Outlook	Stable

* Debt guaranteed by NiSource Inc.

Source: Moody's Investors Service

ANALYST CONTACTS

Lesley Ritter 212-553-1607
Analyst
lesley.ritter@moodys.com

Michael G. Haggarty 212-553-7172
Associate Managing Director
michael.haggarty@moodys.com

NiSource Inc.

As a Pure-Play Utility, Stable Cash Flow Will Help Offset High Leverage

» NiSource Inc.**'s credit metrics will weaken for the foreseeable future following the spin-off of its natural gas pipeline segment later this year.** Although the company plans to pay down about $2.75 billion of debt as part of the corporate separation, NiSource's leverage will remain significant and will weigh on its credit metrics.

» **But the stability of NiSource's remaining operating cash flows will largely offset the risk posed by its high debt levels.** As a holding company of a portfolio of seven fully rate-regulated utilities operating in credit-supportive regulatory jurisdictions, NiSource will generate stable and predictable operating cash flows, somewhat mitigating its high leverage.

» **NiSource's supportive regulatory compact has now become the crux of the company's credit quality.** NiSource's utility subsidiaries benefit from credit-supportive rate mechanisms that underpin the stability of NiSource's operating cash flow generation. These rate constructs shield the company from significant revenue fluctuations and provide timely recovery of operating and capital costs.

» **Moreover, local distribution companies (LDCs) will generate most of NiSource's earnings.** With no exposure to the risks associated with owning power-generation assets, LDCs carry lower business risk than their vertically integrated electric utility counterparts. Furthermore, the size and broad geographic footprint of NiSource's LDC operations offer regulatory diversity and provide a natural hedge against material exposure to a single jurisdiction.

» **As an owner of generation assets, NiSource's electric subsidiary is inherently riskier.** Generation plants are typically the most expensive part of a utility's infrastructure and are subject to greater construction and operational risk, among others. Even so, the regulatory environment is favorable and available tracker mechanisms add to the stability and timeliness of much of the electric subsidiary's cost recovery.

NiSource's credit metrics will weaken for the foreseeable future following the spin-off

Although NiSource (Baa2 stable for its guaranteed financing vehicle) plans to pay down about $2.75 billion of debt later this year as part of the spin-off of its natural gas pipeline segment, Columbia Pipeline Group (Baa2 stable), its remaining leverage will nonetheless be significant and will weigh on its credit metrics.

NiSource issues most of its debt through NiSource Finance Corp. (NFC) and does not break out its intercompany loans. But by adjusting the company's consolidated debt by the amount of debt implied by each subsidiary's targeted capital structure (see appendix), we estimate that NiSource's holding company debt after the separation will be about $4 billion and will remain at about 50% of consolidated levels (Exhibit 1).

Although this holding company debt is not structurally subordinated, since the vast majority of NiSource's debt is issued by NFC, with identical priority in the capital structure, its share of consolidated debt points to NiSource's high leverage.

Retail utility rates are calculated based on a targeted capitalization structure approved by regulators under the premise that the rates are sufficient to cover debt service at the utility and provide an equity return to its shareholder. As a result, any debt in excess of the targeted operating company regulatory capital structure depends on the utility's ability to earn a return in excess of its debt service. Equity returns are inherently more volatile and leave NiSource creditors exposed to authorized returns on equity (ROE) and rate constructs that allow the utilities to earn close to their authorized levels.

Exhibit 1

NiSource's holding company debt will stay near 50% after the separation

Estimated Total Debt by Entity	12/31/14 (actual)		12/31/15 (pro forma)	
NiSource Finance Corp.	$4,697	47%	$3,947	50%
LDCs (including NIPSCO's LDC)	2,398	24%	2,398	30%
NIPSCO (electric)	1,604	16%	1,604	20%
CPG*	1,300	13%	n/a	n/a
Total	9,999		7,949	

Notes: Figures are in millions. NFC amount in the table includes $109 million in debt outstanding under NiSource Capital Markets Inc. (Baa2 stable), NiSource's predecessor financing arm. * For purposes of this exercise, Moody's assumed that $2.75 billion in debt is will be paid down as part of the spin-off, with the $2.75 billion split between CPG and NFC.

Source: Moody's Investors Service estimates, Company website, SNL

Holding company debt is fairly common in the regulated utility sector, but there are only limited instances in our rated universe of regulated utilities where holding company debt exceeds 20% (Exhibit 2).

Exhibit 2

Only a few of the regulated utilities we rate have holding company debt that exceeds 20%

Select Holding Company	Rating	Outlook	Holding Company Debt (% of Consolidated Debt)
NiSource	*Baa2*	*Stable*	*~50%*
Duke Energy Corporation	A3	Stable	30%
WGL Holdings	A3	Stable	27%
TECO Energy Inc.	Baa1	Stable	35%
CMS Energy Corp	Baa2	Stable	30%
Laclede Group (The)	Baa2	Stable	50%
IPALCO Enterprises	Baa3	Stable	40%
Puget Energy Inc.	Baa3	Stable	27%
DPL Inc.	Ba3	Stable	60%

Sources: Company financials, Moody's Investor Services estimates

This publication does not announce a credit rating action. For any credit ratings referenced in this publication, please see the ratings tab on the issuer/entity page on www.moodys.com for the most updated credit rating action information and rating history.

These elevated debt levels are particularly apparent in NiSource's meager debt coverage metrics, which we expect will be both weak for the rating and weak relative to its utility peers (Exhibit 3). This highlights the importance of NiSource's ability to generate stable and predictable operating cash flow to avoid further deterioration in its credit metrics.

Exhibit 3
NiSource's credit metrics are materially weaker than its LDC counterparts

Issuer Name	Rating	Outlook	Date	Int exp + CFO pre-WC/Int exp (3yr avg)	CFO pre-WC/D (3yr avg)	CFO pre-WC - Div/D (3yr avg)	Debt/ Capitalization (3yr avg)
NiSource Pro Forma	*Baa2*	*stable*	*Pro Forma*	*3 - 4x*	*11-14%*	*9-12%*	*49-53%*
Atmos Energy Corporation	A2	stable	9/30/2014	5.7x	24%	19%	43%
ONE Gas, Inc	A2	stable	12/31/2013	5.5x	20%	16%	43%
Piedmont Natural Gas Company, Inc.	A2	stable	10/31/2014	6.7x	21%	15%	47%
Northwest Natural Gas Company	A3	stable	9/30/14 (LTM)	5.3x	21%	17%	47%
WGL Holdings, Inc.	A3	stable	9/30/2014	9.0x	31%	24%	38%
CenterPoint Energy, Inc.	Baa1	stable	9/30/14 (LTM)	4.2x	18%	14%	52%
Laclede Group, Inc. (The)*	Baa2	stable	9/30/2014	5.1x	12%	8%	49%
AGL Resources Inc.	WR	n/a	9/30/14 (LTM)	5.6x	18%	13%	49%

*Laclede Group, Inc.'s financial ratios for the reported period reflect the full impact of the debt associated with the company's September 2014 acquisition of Alabama Gas Company but only account for Alagasco's operating cash flows from the acquisition date. We expect Laclede's CFO pre-WC/D metric to return to 14-19% and CFO pre-WC less dividend/D metrics to return to 10-15% over the next 12-18 months, reflecting a full year of operations as a combined entity.

Source: Moody's Investor Services

But the stability of the remaining operating cash flows largely offsets weak credit metrics

As a holding company to a portfolio of seven fully rate-regulated utilities operating under credit-supportive regulatory jurisdictions, NiSource's remaining businesses will generate stable and predictable operating cash flows that mitigate the negative impact of the company's higher debt levels.

NiSource's LDCs will represent about 65% of consolidated operating earnings on a post-separation basis, a credit positive because most of its cash flow will now be generated by the least risky part of its business. We believe LDCs carry less business risk than their vertically integrated electric counterparts. They are not engaged in power generation, typically the most expensive part of a utility's infrastructure, and are not exposed to the construction and operation of generation assets.

Furthermore, NiSource operates LDCs across seven states, representing 3.4 million customers and an annual consolidated rate base of $4.4 billion, making it the fourth-largest LDC in the US (based on number of customers; see Appendix C).

Over the past 10 years, the company has completed a round of rate cases across all of its jurisdictions that have increased theLDC segment's operating income 18% andraised consolidated non-volumetric revenue recovery. NiSource has also benefitted from the adoption of favorable regulatory rate-making mechanisms across its footprint. Currently, 81% of its LDC rate base is covered by either straight-fixed variable mechanisms or decoupling mechanisms that support stable revenue generation and protect the LDCs against changes in demand (Exhibit 4). The fixed-cost component of the company's distribution charge, which grew from an average of 36% in 2007 to over 80% in 2014, adds to the stability of operating income. Finally, the adoption of a forward test year in Pennsylvania increases the predictability of earnings as well.

Exhibit 4

NiSource's rate constructs support stable earnings

LDC	Share of Rate Base	Fixed Cost Component (% of Distribution Charge)	Decoupling / Weather Normalization	Forward Test Year
Columbia Gas of Ohio	32%	100%	Straight-fixed variable	n/a
Columbia Gas of Pennsylvania	22%	~50%	Weather normalization	Yes
NIPSCO Gas	18%	~60%	n/a	No*
Columbia Gas of Massachusetts	11%	~30%	Decoupling	No
Columbia Gas of Virginia	11%	~55%	Decoupling Weather normalization	No
Columbia Gas of Kentucky	5%	~60%	Weather normalization	No
Columbia Gas of Maryland	1%	~35%	Decoupling	No

* SB 560, enacted in 2013, provides for utilities to utilize a historical test year, a forward-looking test year, or a "hybrid" test year that includes both historical and projected data. No Indiana Utility Regulatory Commission regulated utility has filed a general rate case using a forward-looking test year to date.

Source: Company presentations

A Few Industry Terms

A **revenue decoupling mechanism** allows the utility to defer fixed distribution costs that the utility fails to recoup through its volumetric charges due to customer participation in conservation programs, lowering revenues. The utility is then allowed to recover the deferrals associated with unrecovered fixed costs through a surcharge mechanism over a period of time.

A **straight-fixed variable rate design** allows all of the utility's fixed costs to be recovered through the fixed monthly customer charge, and therefore, sales fluctuations caused by weather, customer participation in demand-side management programs and economic conditions do not impact the company's recovery of its fixed costs.

Forward test year allows the utility to use a forward-looking test year when filing a rate case. State utility commission typically use the concept of a "test year" — a consecutive 12-month period deemed to be a representative year for a utility in terms of costs and revenues relative to the year that rates will be in effect. A future test year uses projections and utility resource planning to derive forward looking revenue requirements in rate setting.

Weather normalization adjustment decouples the utility's revenues from the impact of weather on its distribution revenues.

Source: Moody's Investors Service

NiSource's regulatory compact is at the crux of the company's credit quality

NiSource's utility subsidiaries benefit from credit-supportive regulatory constructs across the majority of the company's footprint. In addition to a high degree of certainty around the LDCs' fixed operating-cost recovery, NiSource has secured trackers assuring recovery of about 60% of its planned capital expenditures and 100% of its infrastructure modernization programs (Exhibit 5).

Exhibit 5

System modernization trackers offer timely investment recovery

LDC	Share of Rate Base	Infrastructure Tracker	Regulatory Treatment
Columbia Gas of Ohio	32%	Accelerated Main Replacement Program	Tracker
Columbia Gas of Pennsylvania	22%	Distribution, and Storage System Improvement Charge	Forward Test Year / Tracker
NIPSCO Gas	18%	Transportation, Distribution, and Storage System Improvement Charge	Tracker / Rate case
Columbia Gas of Massachusetts	11%	Targeted Infrastructure Recovery Factor	Forward looking tracker
Columbia Gas of Virginia	11%	Steps to Advance Virginia's Energy Plan	Forward looking tracker
Columbia Gas of Kentucky	5%	Accelerated Main Replacement Program	Forward looking tracker
Columbia Gas of Maryland	1%	Strategic Infrastructure Development and Enhancement	Forward looking tracker / Rate case

Source: Company website

The regulatory treatment of the system modernization investments provides for near simultaneous recovery in spending, significantly reducing recovery lag and protecting the company against potential disallowances. These recovery mechanisms offer visibility into the size and timing of the cash flow from NiSource's investments, a concern since the company will most likely finance a portion of its planned capital expenditure through further debt issuances. However, we expect that the incremental debt will be serviced with timely incremental operating cash flow streams, which will allow NiSource to avoid further credit-metric erosion and keep its cash-flow coverage metrics in the low teens.

NiSource's electric subsidiary is inherently riskier

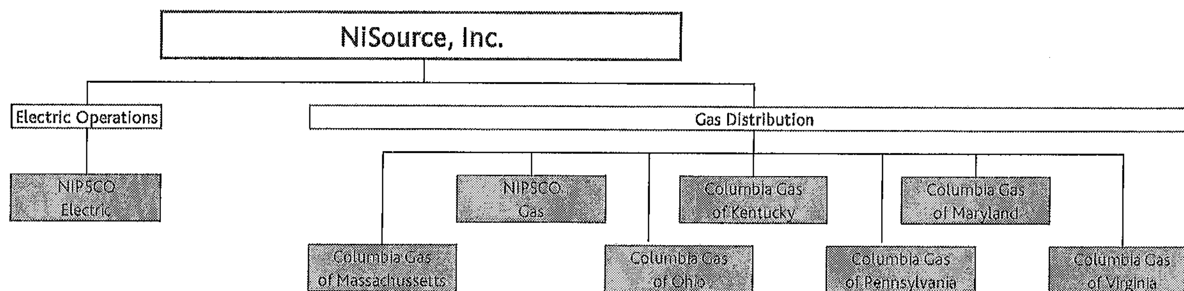
As an owner of generation assets, NiSource's electric subsidiary, Northern Indiana Public Service Company (NIPSCO, Baa1, stable) is inherently riskier than the LDC business.

The segment, which represents 35% of consolidated earnings, owns 3.3 gigawatts (GW) of generation capacity, including 2.5 GW of coal-fired units. The make-up of its service territory is also less credit supportive than those of its sister LDC companies. NIPSCO's electric operations are concentrated in a single, highly industrialized market territory. Fifty percent of the company's retail electric sales volumes are derived from industrial customers, leaving it particularly sensitive to economic cycles. Also, the electric segment does not have access to the decoupling mechanisms available to NiSource's LDCs.

Even so, Indiana's regulatory environment is generally favorable from a credit standpoint and provides the company with an attractive suite of mechanisms that cover most of its operating and capital expenses. For example, the company has received the necessary tracker approval for 70% of its planned capital investments through 2020. NIPSCO has also secured regulatory approval for recovery of its environmental upgrades, and we expect that any future prudently incurred upgrades associated with the pending carbon regulations would likely qualify for recovery under Indiana's environmental trackers as well.

Finally, the company's latest Integrated Resource Plan, released in 2014, does not envision the need for new power generation investment to satisfy load requirements for the foreseeable future, a credit positive since it further supports the relative ongoing stability of NiSource's electric segment.

Appendix A: NiSource's organizational structure after the spin-off



Source: Company presentation

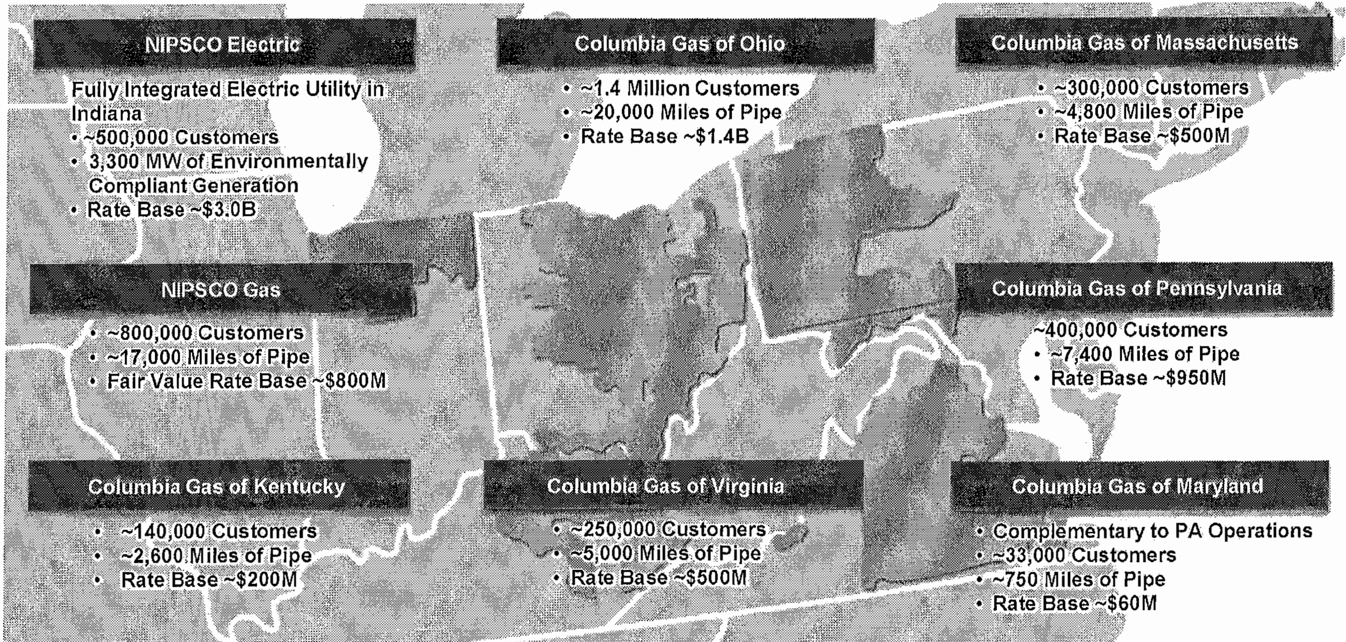
Appendix B: Targeted Regulatory Capital Structures

	Rate Base ($MM)	Target Regulatory Equity Ratio (%)	Estimated Long-term debt ($MM)
LDC segment			
Columbia Gas of Ohio	1,400	58.60%	580
Columbia Gas of Pennsylvania	950	52.17%	464
NIPSCO Gas	800	46.29%	430
Bay State Gas	500	53.68%	232
Columbia Gas of Virginia	500	42.70%	287
Columbia Gas of Kentucky	200	52.39%	95
Columbia Gas of Maryland	60	53.84%	28
Total estimated long-term debt at LDCs			2,114
Add: Accounts Receivable debt			284
Total estimated debt at LDCs			2,398
Electric segment			
NIPSCO Electric	3,000	46.53%	1,604
Total estimated debt at electric segment			1,604

Source: Company presentation, SNL

Appendix C: NiSource's footprint spans seven jurisdictions

The size of the LDCs' footprint provides NiSource with scale and diversity, shielding it from the economic and regulatory concentration risks associated with more centralized operations.



Source: Company presentation

Moody's Related Research

Credit Opinions:

» NiSource Inc.

» Northern Indiana Public Service Company

Pre-Sale Report:

» Columbia Pipeline Group, Inc.

Special Comment:

» High Leverage at the Parent Often Hurts the Whole Family, May 2015 (1002758)

» NiSource: Re-Tooling as a Midstream Player in the Utica Shale, November 2012 (147561)

Rating Methodology:

» Regulated Electric and Gas Utilities, December 2013 (157160)

To access any of these reports, click on the entry above. Note that these references are current as of the date of publication of this report and that more recent reports may be available. All research may not be available to all clients.

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ANALYST CONTACTS

NEW YORK

Lesley Ritter 1.212.553.1607
Analyst
lesley.ritter@moodys.com

Moody's
INVESTORS SERVICE

Rating Action: Moody's Affirms the ratings for NiSource Inc. and its subsidiaries; rating outlooks remain stable

Global Credit Research - 17 Jun 2015

New York, June 17, 2015 -- Moody's Investors Service ("Moody's") affirmed the ratings for NiSource, Inc. and its rated subsidiaries in anticipation of the imminent completion of its corporate separation, originally announced in September 2014. The spinoff of its natural gas pipeline and midstream assets, scheduled for 1 July 2015, entails NiSource splitting into two publicly traded companies: NiSource Inc.: a holding company with a portfolio of fully regulated electric and natural gas distribution utility subsidiaries: and Columbia Pipeline Group (CPG, Baa2 senior unsecured): a pure play natural gas pipeline, midstream and storage company. Today's rating affirmation does not include CPG. Ratings affirmed include the Baa2 senior unsecured rating and P-2 Commercial Paper rating for NiSource Finance Corporation, the principal funding vehicle for the NiSource family; the Baa2 rating for NiSource Capital Market's Inc., the legacy funding vehicle for the NiSource family, the Baa2 senior unsecured rating for Bay State Gas Company (Bay State), which reflects the guarantee from NiSource, Inc., and the Baa1 senior unsecured rating for Northern Indiana Public Service Company (NIPSCO). The (P) Ba1 preferred shelf for NiSource Inc., the ultimate parent company, was also affirmed. The rating outlooks for all of NiSource's rated entities are stable.

"NiSource's Baa2 rating reflects the low business risk and good diversity of its electric and natural gas distribution businesses" said Lesley Ritter, Analyst. "All six utility subsidiaries operate in supportive regulatory jurisdictions, where a $7.8 billion rate base will generate stable and predictable cash flows over the next few years, thereby mitigating NiSource's high leverage".

RATINGS RATIONALE

The Baa2 rating for NiSource primarily reflects its rate-regulated, low business risk utility assets. These businesses include six local distribution companies (representing approximately 55% of total consolidated rate base) and one combination vertically integrated electric and gas distribution utility, Northern Indiana Public Service Company (NIPSCO: Baa1 stable). The regulatory authorities that oversee these utilities are supportive to long-term credit quality because they provide an attractive suite of timely recovery mechanisms for prudently incurred costs and investments and authorized equity returns are at or above the national average. These utility operations also benefit from numerous special rate riders and trackers that shield approximately 65% of revenues from volumetric-related fluctuations. NiSource also benefits from good geographic diversity and size, with a footprint spanning seven states across the Northeast quadrant of the US, and a low business risk profile with natural gas distribution companies representing approximately 65% of consolidated operating income. Combined, the supportiveness of NiSource's regulatory jurisdictions and its good geographic diversity, are viewed as a material credit positive.

The rating is constrained by NiSource's weak financial profile, primarily relating to its significant leverage. Furthermore, NiSource's extensive capital investment projects will continue to pressure its debt coverage and capitalization ratios over the coming years. As a result, we expect NiSource will apply a conservative financing approach to its capital investments, including a balanced mix of debt and equity.

"NiSource's high debt level appears unlikely to change for the foreseeable future, and will pressure consolidated metrics, including a ratio of cash flow to debt in the 12-13% range over the next few years. Although the financial profile reflects only a limited amount of financial flexibility, we do not see the credit profile deteriorating." Ritter added.

NiSource's stable outlook reflects our expectation that its financial profile will decline modestly due to its corporate separation, but only temporarily. A debt to capitalization ratio of approximately 50% is expected as well as a decline in its cash flow to debt to the 12-13% range before slowly rising closer to the mid-teens range towards the end of the decade. The stable outlook reflects and anticipates the completion of the corporate separation in line with the company's outlined timeline and terms, and incorporates a view that NiSource's regulated utility capital expenditure plans will be financed in a balanced manner. The outlook also takes into account the credit supportiveness of NiSource's regulatory environments, the low business risk associated with its LDC operations, and the scale and scope of its footprint, that together mitigate metrics that are weak for the rating.

NIPSCO's Baa1 rating reflects the company's healthy standalone credit metrics and favorable regulatory environment. The rating is constrained by its geographic concentration in northern Indiana and a mature and highly industrialized service area, leaving it particularly exposed to macroeconomic fluctuations. The one-notch difference in the rating of NIPSCO and NiSource takes into account the implicit burden of substantial debt at the parent level and the fairly unrestricted movement of cash among its affiliates in a centralized money pool.

NIPSCO's stable outlook reflects the parent's stable outlook, the credit supportiveness of its regulatory environment, and the expectation that the company will continue to recover its large capital investment program on a timely basis. The outlook also anticipates a that any funding shortfall will be prudently funded.

What Could Change the Rating -- Up

An upgrade at NiSource could be considered if there was further improvement in the utility's regulatory environment or if the cash flow to debt ratio rises to the high teens and interest coverage exceeds 4.0x on a sustained basis.

NIPSCO's rating could be raised if there is an improvement in the regulatory environment that led to meaningfully greater predictability, timeliness and/or sufficiency of rates such that financial metrics would be expected to improve, specifically if CFO pre-WC to debt rises above 24% and interest coverage to over 5.0x on a sustained basis. An upgrade at NiSource could also place upward rating pressure on NIPSCO.

What Could Change the Rating - Down

The rating could be downgraded if there is a decline in credit supportiveness of NiSource's regulatory environments, an adverse change in the company's business mix such that its business risk profile deteriorates, or if debt coverage and interest coverage fall below 12% and 3.0x, on a sustained basis.

NIPSCO's rating could be downgraded if it experiences a deterioration in its relationship with its primary regulators or if its CFO pre-WC to debt metrics fell to the mid-teens on a sustained basis. NIPSCO's rating could come under downward pressure if its parent adopted an aggressive corporate finance strategy where it would place additional reliance on dividends from its regulated subsidiary to service the parent debt. Finally, a downgrade at NiSource could also place downward rating pressure on NIPSCO.

Any change in Bay State's rating or outlook is linked to a change in its parent rating or outlook.

Outlook Actions:

..Issuer: Bay State Gas Company

....Outlook, Remains Stable

..Issuer: NiSource Capital Markets, Inc.

....Outlook, Remains Stable

..Issuer: NiSource Finance Corporation

....Outlook, Remains Stable

..Issuer: NiSource Inc.

....Outlook, Remains Stable

..Issuer: Northern Indiana Public Service Company

....Outlook, Remains Stable

Affirmations:

..Issuer: Bay State Gas Company

....Senior Unsecured Medium-Term Note Program, Affirmed (P)Baa2

....Senior Unsecured Regular Bond/Debenture, Affirmed Baa2

..Issuer: Jasper (County of) IN - Supported by Northern Indiana Public Service Company

....Senior Secured Revenue Bonds, Affirmed A1/VMIG 1

....Senior Unsecured Revenue Bonds, Affirmed Baa1

..Issuer: NiSource Capital Markets, Inc.

....Backed Senior Unsecured Regular Bond/Debenture, Affirmed Baa2

..Issuer: NiSource Finance Corporation

.... Issuer Rating, Affirmed Baa2

....Senior Unsecured Bank Credit Facility, Affirmed Baa2

....Backed Senior Unsecured Commercial Paper, Affirmed P-2

....Backed Senior Unsecured Regular Bond/Debenture, Affirmed Baa2

....Backed Senior Unsecured Shelf, Affirmed (P)Baa2

..Issuer: NiSource Inc.

....Preferred Shelf, Affirmed (P)Ba1

....Preferred Shelf - PS2, Affirmed (P)Ba1

..Issuer: Northern Indiana Public Service Company

.... Issuer Rating, Affirmed Baa1

....Senior Unsecured Medium-Term Note Program, Affirmed (P)Baa1

....Senior Unsecured Regular Bond/Debenture, Affirmed Baa1

The principal methodology used in these ratings was Regulated Electric and Gas Utilities published in December 2013. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

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Lesley Ritter
Analyst
Infrastructure Finance Group
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

William L. Hess
MD - Utilities
Infrastructure Finance Group
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

Releasing Office:
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A.
JOURNALISTS: 212-553-0376
SUBSCRIBERS: 212-553-1653

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Research Update:

NiSource Inc. And Subsidiaries Ratings Raised To 'BBB+' From 'BBB-' On Spin-Off; Outlook Stable

Primary Credit Analyst:
Gerrit W Jepsen, CFA, New York (1) 212-438-2529; gerrit.jepsen@standardandpoors.com

Secondary Contact:
Matthew L O'Neill, New York (1) 212-438-4295; matthew.oneill@standardandpoors.com

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Research Update:

NiSource Inc. And Subsidiaries Ratings Raised To 'BBB+' From 'BBB-' On Spin-Off; Outlook Stable

Overview

- U.S. utility holding company NiSource Inc. is expected to complete its divestiture of its pipeline and midstream energy subsidiary Columbia Pipeline Group (CPG) on July 1, 2015. The CPG divestiture will leave NiSource as a regulated utility holding company that will have a business risk profile that we consider "excellent" compared to "strong" with the inclusion of the CPG business.
- We expect NiSource to complete the spin-off on July 1, 2015, as indicated by the company.
- We are raising our issuer credit rating (ICR) on NiSource Inc. to 'BBB+' from 'BBB-' and removing the rating from CreditWatch.
- We are raising our ICRs on utility subsidiaries Northern Indiana Public Service Co. and Bay State Gas Co., as well as finance entities NiSource Finance Corp. and NiSource Capital Markets Inc., to 'BBB+' from 'BBB-'.
- We are raising our short-term rating on NiSource and NiSource Finance to 'A-2' from 'A-3'.
- The rating outlooks are stable based on our expectation that NiSource will continue to effectively manage its regulatory risk, thereby supporting consistent operating results of the remaining utility company and a financial risk profile in line with expectations at the 'BBB+' rating.

Rating Action

On June 18, 2015, Standard & Poor's Ratings Services raised its issuer credit rating (ICR) on utility holding company NiSource Inc., its operating subsidiaries Northern Indiana Public Service Co. (NIPSCO) and Bay State Gas Co., and its finance entities NiSource Finance Corp. and NiSource Capital Markets Inc., to 'BBB+' from 'BBB-'. At the same time, we removed the ratings from CreditWatch, where they were placed with positive implications on Sept. 29, 2014. The outlook is stable. We also raised the short-term ratings on NiSource and NiSource Finance to 'A-2' from 'A-3'.

Rationale

NiSource is nearing the spin-off of the higher-risk pipeline and midstream energy business, Columbia Pipeline Group (CPG), resulting in sufficient improvement in business risk to revise the company's business risk profile to "excellent" from "strong". Following this divestiture, NiSource's pro forma operating earnings will be about two-thirds low-risk regulated natural gas

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distribution utility operations and one-third vertically integrated electric utility operations. The "excellent" business risk assessment incorporates NiSource's focus only on regulated utility operations where there is geographical and operating diversity with numerous utilities that serve more than 3.3 million natural gas distribution customers in seven states from Indiana to Massachusetts and 450,000 electricity customers in northern Indiana.

We base our assessment of NiSource's business risk profile on the company's "strong" competitive position and "very low" industry risk derived from the regulated utility industry and the "very low" country risk of the U.S. where the company operates. NiSource's competitive position partly reflects the stable regulatory framework of the low-risk regulated utility operations. We consider the company's gas distribution operations to be above average, characterized by ample geographic diversity and integration with the company's gas transmission network, which provides operational flexibility. Nearly all of the gas distribution subsidiaries' needs are contracted, with roughly 70% of peak gas needs met with storage gas. This bolsters service reliability, thereby supporting the business risk profile. Cash flow variability is also low given material revenue stabilization and cost-tracking mechanisms. NIPSCO is a vertically integrated electric and natural gas utility providing service mostly in northern Indiana. It has flat customer growth and above-average industrial exposure, largely to the steel-related industry. The utility has been installing environmental compliance equipment and using an environmental rate surcharge for timely recovery of costs. Base rates and various rate surcharges support cost recovery. Rates are above the state average, but not the highest in Indiana.

Based on the medial volatility financial ratio benchmarks, our assessment of NiSource's financial risk profile is significant. This takes into consideration the removal of midstream assets and the corresponding debt after the CPG spin-off and sustained cash flows from the regulated utility operations through ongoing rate recovery of capital expenditures and operating expenses. Over the next three years, we expect that NiSource will continue to seek external financing since under our baseline forecast the company will generate an annual deficit in discretionary cash flow, or remaining operating cash flow after its capital spending and dividends. Our baseline forecast includes financial measures plateauing, with funds from operations (FFO) to debt ranging between about 12.5% and 14% through 2018 and operating cash flow (OCF) to debt ranging between about 13% and 16% over the same period. The financial measures include the effects of volume growth coupled with cost recovery through riders offset by moderate operations and maintenance increase.

Liquidity

NiSource has "adequate" liquidity, as our criteria define the term. The company's sources of liquidity are likely to cover its uses by more than 1.1x in the next 12 months. We expect NiSource to meet cash outflows even with a 10% decline in EBITDA. As such, NiSource benefits from stable cash flow

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generation, availability under its revolving credit facility and access to capital markets. There are sizable debt maturities but we expect the company to refinance these given its satisfactory standing in the credit markets.

Principal liquidity sources:
We forecast FFO of about $1.2 billion for 12 months ending March 31, 2016.
Average availability of about $1.5 billion under the credit facility following the spin-off.
Asset sale of roughly $3 billion for 12 months ending March 31, 2016.

Principal liquidity uses:
Capital spending of about $1.5 billion for 12 months ending March 31, 2016.
Dividends of roughly $200 million for 12 months ending March 31, 2016.
Debt maturities and redemptions of about $3.6 billion for the period ending March 31, 2016.
Working capital outflows of about $105 million for 12 months ending March 31, 2016.

Outlook

The stable rating outlook on NiSource reflects our expectation that management will focus on its fully regulated utilities. The outlook also reflects our expectations that cash flow protection and debt leverage measures will be appropriate for the rating. Specifically, our baseline forecast includes FFO to total debt between 12.5% and 14% and OCF to debt between 13% and 16%. Given the company's regulated focus, we expect that NiSource will avoid any meaningful rise in business risk by reaching constructive regulatory outcomes.

Downside scenario

We could lower ratings if unregulated operations are added to the fully regulated company. Ratings could also be lowered if core financial measures were to consistently underperform our base-case forecast and remain consistently at less credit-supportive levels, including adjusted FFO to debt consistently below 12%. This could occur if cost recovery is not as timely as expected, construction projects are over budget or if capital expenditures exceed forecasted levels and is primarily debt financed.

Upside scenario

Although unlikely over the next few years, we could raise the ratings if the business risk profile further strengthened or if financial measures exceeded our baseline forecast on a consistent basis, including FFO to total debt over 18%. Improved financial measures could occur through more robust cost recovery, debt retirement, or greater equity funding.

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Other Credit Considerations

The ratings on NiSource include a one-notch negative adjustment for comparable rating analysis that reflects NiSource's weak financial ratios within the significant financial risk profile.

Group Influence

Under the group rating methodology, we view NiSource as the parent of the group whose members are NIPSCO, Bay State Gas, NiSource Finance, and NiSource Capital Markets. As a result, NiSource's group and stand-alone credit profiles are the same at 'bbb+'.

Ratings Score Snapshot

Corporate Credit Rating: BBB+/Stable/A-2

Business risk: Excellent
- Country risk: Very low
- Industry risk: Very low
- Competitive position: Strong

Financial risk: Significant
- Cash flow/Leverage: Significant

Anchor: a-

Modifiers
- Diversification/Portfolio effect: Neutral (no impact)
- Capital structure: Neutral (no impact)
- Financial policy: Neutral (no impact)
- Liquidity: Adequate (no impact)
- Management and governance: Satisfactory (no impact)
- Comparable rating analysis: Negative (-1 notch)

Stand-alone credit profile: bbb+
Group credit profile: bbb+

Recovery Analysis

NiSource has fully guaranteed the debt of Bay State Gas Co. and financing entity NiSource Finance, and most of the debt of finance entity NiSource Capital Markets. The short-term rating is 'A-2' based on our ICR on the company and our assessment of its liquidity as at least adequate. We rate the senior unsecured debt at NiSource Finance and NiSource Capital Markets the

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same as the ICR because priority liabilities, including operating utility debt, are less than 20% of total assets.

Related Criteria And Research

Related Criteria

- Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Dec. 16, 2014
- Key Credit Factors For The Regulated Utilities Industry, Nov. 19, 2013
- Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- Methodology: Industry Risk, Nov. 19, 2013
- Group Rating Methodology, Nov. 19, 2013
- Corporate Methodology, Nov. 19, 2013
- Country Risk Assessment Methodology And Assumptions, Nov. 19, 2013
- Methodology For Linking Short-Term And Long-Term Ratings For Corporate, Insurance, And Sovereign Issuers, May 7, 2013
- Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- Stand-Alone Credit Profiles: One Component Of A Rating, Oct. 1, 2010
- 2008 Corporate Criteria: Rating Each Issue, April 15, 2008

Ratings List

Upgraded; CreditWatch/Outlook Action

	To	From
NiSource Inc.		
Corporate Credit Rating	BBB+/Stable/A-2	BBB-/Watch Pos/A-3
Bay State Gas Co.		
Corporate Credit Rating	BBB+/Stable/--	BBB-/Watch Pos/--
Senior Unsecured	BBB+	BBB-/Watch Pos
NiSource Capital Markets Inc.		
Corporate Credit Rating	BBB+/Stable/--	BBB-/Watch Pos/--
Senior Unsecured	BBB+	BBB-/Watch Pos
NiSource Finance Corp.		
Corporate Credit Rating	BBB+/Stable/A-2	BBB-/Watch Pos/A-3
Senior Unsecured	BBB+	BBB-/Watch Pos
Commercial Paper	A-2	A-3/Watch Pos
Northern Indiana Public Service Co.		
Corporate Credit Rating	BBB+/Stable/--	BBB-/Watch Pos/--
Senior Unsecured	BBB+	BBB-/Watch Pos

Affirmed

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Northern Indiana Public Service Co.
Senior Unsecured* AA-/Stable

*Northern Indiana Public Service Co. is the obligor of issuances.

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MOODY'S
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Credit Opinion: NiSource Inc.

Global Credit Research - 18 Jun 2015

Merrillville, Indiana (State of), United States

Ratings

Category	Moody's Rating
Outlook	Stable
Pref. Shelf	(P)Ba1
NiSource Finance Corporation	
Outlook	Stable
Issuer Rating	Baa2
Sr Unsec Bank Credit Facility	Baa2
Senior Unsecured	Baa2
Bkd Commercial Paper	P-2
Northern Indiana Public Service Company	
Outlook	Stable
Issuer Rating	Baa1
Senior Unsecured	Baa1
NiSource Capital Markets, Inc.	
Outlook	Stable
Bkd Senior Unsecured	Baa2
Bay State Gas Company	
Outlook	Stable
Senior Unsecured	Baa2

Contacts

Analyst	Phone
Lesley Ritter/New York City	212.553.1607
William L. Hess/New York City	212.553.3837

Key Indicators

[1]**NiSource Inc.**

	3/31/2015(L)	12/31/2014	12/31/2013	12/31/2012	12/31/2011
CFO pre-WC + Interest / Interest	4.3x	4.1x	4.1x	4.3x	3.9x
CFO pre-WC / Debt	16.5%	13.4%	14.9%	16.5%	13.9%
CFO pre-WC - Dividends / Debt	13.0%	10.4%	11.6%	13.4%	10.9%
Debt / Capitalization	45.6%	52.1%	50.4%	51.3%	53.3%

[1] All ratios are based on 'Adjusted' financial data and incorporate Moody's Global Standard Adjustments for Non-Financial Corporations. Source: Moody's Financial Metrics

Note: For definitions of Moody's most common ratio terms please see the accompanying User's Guide.

Opinion

Rating Drivers

- NiSource set to become a fully regulated utility company on 1 July 2015

- Persistent high debt balance and elevated investment spend weigh on financial profile

- Stability of cash flows underpinned by supportive regulatory constructs that largely offset high leverage

- Regulated utility assets carry low business risk

Corporate Profile

Following NiSource Inc.'s (Baa2, senior unsecured for its guaranteed financing vehicle, NiSource Finance Corp.) 1 July 2015 corporate separation from Columbia Pipeline Group (CPG, Baa2, stable), the company will become a holding company with a portfolio of regulated utility subsidiaries. More specifically, NiSource will own one of the largest natural gas local distribution companies (LDCs) in the US, with operations in Ohio, Indiana, Pennsylvania, Virginia, Massachusetts, Kentucky, and Maryland and over 3.4 million customers, as well as a mid-sized vertically integrated electric utility in Indiana. The LDCs will account for about 65% of the company's consolidated operating earnings, with the balance coming from its electric utility. Two of NiSource's utility subsidiaries are rated: Bay State Gas Company (Bay State Gas, doing business as Columbia Gas of Massachusetts, Baa2 senior unsecured, stable) and Northern Indiana Public Service Company (NIPSCO, Baa1 senior unsecured, stable).

On 17 June 2015, we affirmed the Baa2 senior unsecured rating for NiSource's guaranteed financing vehicle ahead of the completion of its corporate separation, as well as Bay State Gas' Baa2 senior unsecured rating and NIPSCO's Baa1 senior unsecured rating. The outlook is stable.

SUMMARY RATING RATIONALE

NiSource's Baa2 rating reflects the credit supportiveness and diversity of its multiple regulatory jurisdictions that allow the company to generate stable and predictable operating cash flows, the low business risk nature of its operations (approximately 65% of utility operating earnings generated at natural gas LDCs), as well as its broad geographic footprint and scale (approximately 4 million utility customers across seven states). Together, these help mitigate against a weak financial profile as the company manages elevated debt levels while executing on a sizeable capital investment program. We anticipate a ratio of cash flow to debt in the low-teens' range over the next three to five years. The rating also assumes that the company will complete its corporate separation by the intended date and in accordance with the plan outlined to the public.

DETAILED RATING CONSIDERATIONS

NISOURCE TO BECOME FULLY REGULATED UTILITY COMPANY ON 1 JULY 2015

The spin-off of CPG into a separate, publicly listed company, simplifies NiSource's operations and transforms the company into a fully regulated utility holding company. It also removes the uncertainty associated with its pipeline business including contract renewal risk and execution risk on its multibillion dollar capital expenditure program. Furthermore, given the creation of a master limited partnership to finance CPG's capital investments, the separation allows NiSource to maintain a straightforward and transparent corporate financing structure.

PERSISTENT HIGH DEBT BALANCE AND ELEVATED INVESTMENT SPEND WEIGH ON FINANCIAL PROFILE

NiSource's rating is constrained by its weak financial profile, primarily relating to its elevated debt levels which appear unlikely to change for the foreseeable future. Although NiSource is paying down about $2.75 billion of debt as part of its corporate separation, the company's leverage remains significant and weighs on its debt coverage metrics.

The extensive capital investment projects at its utilities, estimated at about $1.4 billion per year through 2020, will place added pressure to the company's financial profile. We anticipate that its debt coverage metrics will decline from their current mid-teen levels over the next few years, falling to the 12-13% range before returning near the mid-teens towards the end of the decade, once new projects begin generating sufficient cash flows to offset the company's leverage. Furthermore, given NiSource's existing debt balance, we expect the company will apply a conservative approach to financing its capital investments, including equity issuances, as necessary to avoid further eroding its debt coverage and debt to capitalization ratios.

STABILITY OF CASH FLOWS UNDERPINNED BY SUPPORTIVE REGULATORY CONSTRUCT LARGELY OFFSET HIGH LEVERAGE

The state regulators overseeing NiSource's utilities are generally credit supportive. Each LDC benefits from decoupling mechanisms and/or weather normalization adjustments which reduce earnings volatility. In addition, NiSource has access to a variety of tracker mechanisms across its different jurisdictions to cover its ongoing infrastructure replacement program, that provide for timely recovery of its sizeable infrastructure investment program. Similarly, NiSource's electric segment benefits from a broad array of tracker mechanisms providing for timely recovery of operating expenses as well as environmental and system modernization investments.

NiSource's LDCs have become steadier and more profitable over the past several years due to rate increases and improved rate design. Over the past 10 years, the company has completed multiple rounds of rate cases across all of its jurisdictions that have increased the LDC segment's operating income 18% and raised consolidated non-volumetric revenue recovery to above 80%.

In 2014, NiSource completed two general rate cases. The Columbia Gas of Massachusetts's (CMA, 11% of consolidated utility rate base) rate case was decided following a fully litigated proceeding with a final order granting about 65% of CMA's requested increased based on a 9.55% return on equity and a 53.68% equity ratio. The Columbia Gas of Pennsylvania (CPA, 22% of consolidated utility rate base) rate case was settled eight months after original filing, resulting in 60% of the requested amount being granted.

Massachusetts continues to be NiSource's most challenging jurisdiction where rate cases are typically fully litigated rather than settled. Nevertheless, we view CMA's latest rate case order as generally credit positive since it granted the company a return on equity that is higher than the one allowed in its 2012 rate order, an equity strong capital structure, as well as the right to continue the company's targeted infrastructure recovery factor, which provides for recovery of its pipeline replacement program.

NiSource currently has three ongoing base rate proceedings underway, that together account for 44% of consolidated utility rate base and, if approved as filed, would represent a total of $127 million in additional base revenues with new rates going into effect over the next nine months.

Among its other 2014 regulatory proceedings, NiSource received regulatory approvals on its seven-year electric and gas investment plans filed in Indiana for a total investment amount of $1.8 billion. Legislation provides for cost recovery outside of a base rate proceeding for new or replacement electric and gas transmission, distribution and storage projects, with 80% of eligible costs being recovered using the TDSIC rider and 20% of the cost being deferred. Despite some noise around TDSIC pertaining to the completeness of the utility's original filing seven-year electric plan, we expect TDSIC along with NiSource's other infrastructure riders to allow the company to recover a significant portion of their sizeable infrastructure investments in a timely fashion, allowing for predictable operating cash flow generation over the near to medium term.

REGULATED UTILITY ASSETS ARE LOW RISK

As of 1 July, 2015, NiSource's seven LDCs will represent about 65% of pro forma operating income, while its vertically integrated electric utility segment make up the difference.

With no exposure to the risks associated with owning power-generation assets, LDCs carry lower business risk than their vertically integrated electric utility counterparts. Furthermore, the size and broad geographic footprint of NiSource's LDC operations offer regulatory diversity and provide a natural hedge against material exposure to a single jurisdiction.

NiSource's electric segment is inherently riskier than the LDC business. In addition to its exposure to the risks associated with generation assets, unlike its LDC counterparts, its operations are concentrated in a single, highly industrialized market territory. About fifty percent of the company's retail electric sales volumes are derived from industrial customers, leaving it particularly sensitive to economic cycles. Also, the electric segment does not have access to the decoupling mechanisms available to NiSource's LDCs.

Still, Indiana's regulatory environment is generally favorable from a credit standpoint and provides the company with an attractive suite of recovery mechanisms that cover most of its operating and capital expenses. Additionally, the company is on schedule to complete the environmental retrofits of its generation fleet on time and on budget. And its latest Integrated Resource Plan, released in 2014, does not envision the need for new power generation investment for the foreseeable future, a credit positive since it further supports the relative stability of NiSource's electric segment.

Notching Considerations

NiSource's operating subsidiary NIPSCO is rated one notch above NiSource to reflect its default probability and the structural seniority of its debt to substantially all of the parent guaranteed debt at NiSource Finance Corp. Bay State's debt is guaranteed by NiSource and consequently has the same rating as NiSource.

As shown in the methodology grid below, the grid indicates a rating of Baa1, which does not reflect the structural subordination that causes the actual parent rating to be Baa2. Ratings within the NiSource family are notched closely because of the company's practice to centrally manage its subsidiaries' cash flow in a corporate money pool and consolidating its debt financing at its guaranteed financing subsidiary NiSource Finance Corp.

Liquidity Profile

NiSource's liquidity is adequate. NiSource maintains a $1.5 billion revolving credit facility due June 2020. The revolver backs its $1.5 billion commercial paper program and provides funds for ongoing working capital needs. Terms of the facility allow for reliable access to funds by not requiring the company to represent and warrant to any material adverse change at each borrowing. The sole financial covenant is a maximum debt-to-capitalization ratio of 70% which the company satisfies as of 31 March 2015, with a debt to capitalization ratio of 53.9%.

NiSource also maintains three separate accounts receivables securitization programs totaling $515 million at its LDCs ($275 million outstanding as of 31 March 2015). The programs are renewed annually.

As of 1 July 2015, NiSource is expected to have about $1.5 billion of available capacity under its revolver, no commercial paper outstanding and about $575 million of cash on hand from the special dividend the company received from CPG to take out NiSource's $230 million notes due November 2015, and $201 million of notes due March 2016.

Rating Outlook

The stable outlook reflects our expectation that NiSource's financial profile will decline modestly due to its planned corporate separation, but only temporarily. A debt to capitalization ratio of approximately 50% is expected as well as a decline in its cash flow to debt to the 12-13% range before slowly rising closer to the low-teens range towards the end of the decade. The stable outlook reflects and anticipates the completion of the corporate separation in line with the company's outlined timeline and terms, and incorporates a view that NiSource's regulated utility capital expenditure plans will be financed in a balanced manner. The outlook also takes into account the credit supportiveness of NiSource's regulatory environments, the low business risk associated with its LDC operations, and the scale and scope of its footprint, that together act to mitigate metrics that are weak for the rating.

What Could Change the Rating - Up

An upgrade could be considered if there was further improvement in the utility's regulatory environment or if there was a material and sustained increase in the company's credit metrics with cash flow to debt in the high teens and interest coverage in excess of 4.0x.

What Could Change the Rating - Down

The rating could be downgraded if there is a decline in the credit supportiveness of NiSource's regulatory environments, an adverse change in the company's business mix or corporate structure such that its business risk profile deteriorates, or if debt coverage and debt to capitalization remain below 12% or above 55%, respectively, on a sustained basis.

Rating Factors

NiSource Inc.

Regulated Electric and Gas Utilities Industry Grid [1][2]	Current LTM 3/31/2015		[3]Moody's 12-18 Month Forward ViewAs of 6/18/2015	
Factor 1 : Regulatory Framework (25%)	**Measure**	**Score**	**Measure**	**Score**
a) Legislative and Judicial Underpinnings of the Regulatory Framework	A	A	A	A

b) Consistency and Predictability of Regulation	A	A	A	A
Factor 2 : Ability to Recover Costs and Earn Returns (25%)				
a) Timeliness of Recovery of Operating and Capital Costs	A	A	A	A
b) Sufficiency of Rates and Returns	A	A	A	A
Factor 3 : Diversification (10%)				
a) Market Position	A	A	A	A
b) Generation and Fuel Diversity	Ba	Ba	Ba	Ba
Factor 4 : Financial Strength (40%)				
a) CFO pre-WC + Interest / Interest (3 Year Avg)	4.3x	Baa	3x - 4x	Baa
b) CFO pre-WC / Debt (3 Year Avg)	16.3%	Baa	11% - 14%	Baa
c) CFO pre-WC - Dividends / Debt (3 Year Avg)	13.0%	Baa	9% - 12%	Baa
d) Debt / Capitalization (3 Year Avg)	48.7%	A	50% - 55%	Baa
Rating:				
Grid-Indicated Rating Before Notching Adjustment		A3		Baa1
HoldCo Structural Subordination Notching	0	0	0	0
a) Indicated Rating from Grid		A3		Baa1
b) Actual Rating Assigned		Baa2		Baa2

[1] All ratios are based on 'Adjusted' financial data and incorporate Moody's Global Standard Adjustments for Non-Financial Corporations. [2] As of 3/31/2015(L); Source: Moody's Financial Metrics [3] This represents Moody's forward view; not the view of the issuer; and unless noted in the text, does not incorporate significant acquisitions and divestitures.

This publication does not announce a credit rating action. For any credit ratings referenced in this publication, please see the ratings tab on the issuer/entity page on http://www.moodys.com for the most updated credit rating action information and rating history.

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Corporates
RAC Template

Fitch Affirms NiSource; Revises Outlook to Positive

Fitch Ratings, New York City, 18 June 2015: Fitch Ratings has affirmed the 'BBB-' long-term Issuer Default Ratings (IDRs) of NiSource Inc. (NI) and its subsidiaries.

Fitch has also revised NI's Rating Outlook to Positive from Stable in anticipation of its separation from Columbia Pipeline Group (CPG, IDR 'BBB-'/Outlook Stable)) on July 1, 2015. After the separation, NI will become a fully regulated natural gas and electric utility holding company.

A complete list of rating actions is provided at the end of this release.

The affirmation and Positive Outlook reflect NI's lower operating risk as a fully regulated holding company in diversified and supportive service territories, better than expected improvement in forecasted credit metrics, and management's willingness to issue equity to preserve credit quality if needed. Although the leverage ratios will continue to be elevated in the intermediate term, the Positive Outlook embeds Fitch's expectation that adjusted debt to EBITDAR will improve to low to mid 4x range toward the end of a five-year forecast period. In its prior review in September 2014, Fitch had identified adjusted debt to EBITDAR threshold of 4.75x on a sustained basis for a positive rating action.

KEY RATING DRIVERS

Low Business Risk
NI's fully regulated business model will be considerably less risky, supported by stable cash flow and earnings from a geographically diverse mix of regulated gas and electric utilities in seven states. Currently, CPG represents approximately 30% of operating earnings. After the separation, gas and electric operations will represent 65% and 35%, respectively, of the operating income. Over time, Fitch expects gas operations will represent a greater share of the total earnings as the company invests more than twice as much capex in its gas utilities as it does in its electric utility. Fitch considers such a trend positive for NI's credit as the regulations governing the gas utilities are considered relatively more supportive and the gas utilities are not subject to the stringent environmental mandates.
Supportive Regulation
The ratings and Positive Outlook also consider the supportive regulatory framework that NI's utilities enjoy in their

respective jurisdictions. This is key for NI’s creditworthiness in light of the aggressive gas system safety and modernization programs at the gas utilities and NIPSCO's environmental capex. Approximately, 75% of capex investment is expected to be recovered through trackers and rate structures with minimal lag and 65% of net revenue is not subject to volume fluctuations.

The gas utility operations have reduced cyclicality and earned stable cash flow through de-coupling mechanisms and trackers. All gas utilities have accelerated infrastructure trackers and energy efficiency programs. Most gas utilities have decoupling, straight fixed variable rates and/or weather normalization mechanisms.

NIPSCO's gas and electric operations are operating under seven-year plans that expire in November 2020. The capex totals $1.9 billion over 2013 to 2020 ($1.1 billion electric investments and $830 million gas investments) for replacement and maintenance of utility equipment, with approximately 75% recovery through semi-annual trackers and the remaining deferred for recovery under a general rate case. NIPSCO's approved environmental spending plan includes over $800 million for generating plant investment which is 100% recoverable through a tracker. NIPSCO’s two MISO transmission projects enjoy FERC’s forward looking rates and CWIP recovery.

High Leverage
NI's leverage will remain high relative to its peers primarily as a result of the legacy debt associated with the acquisition of Columbia Energy Group in November 2000. Additionally, NiSource is undertaking a significant capital expenditure program across the gas and electric segments ($1.4 billion combined annually) compared to $780 million in 2011 and $1 billion in 2012. Such a large program is expected to put pressure on the credit metrics in the intermediate term.

Weak Credit Metrics Expected to Improve
Fitch’s most recent projection indicates that NI's debt to Operating EBITDAR will continue to be elevated through 2018 and decline to approximately 4.6 times (x) in 2019 and 4.3x in 2020. FFO adjusted leverage is expected decline from over 5x in 2016 to 4.7x in 2020 and FFO fixed charge coverage will improve from 3.5x to 3.8x. Fitch's projection incorporates 2014 bonus depreciation benefits and a reasonable amount of equity issuance. Beyond 2020, Fitch expects these metrics, particularly the debt to EBITDAR ratio to improve modestly as various capex programs complete in stages. The FFO metrics

could also benefit from the margin improvement partially offset by expiration of bonus depreciation.

Rating Linkages
NI and NIPSCO's ratings historically were and will continue to be closely linked due to the fact that NI finances substantially all of its utility operations through NIF with guarantee from NI. As of Dec. 31, 2014, NIPSCO had $95.5 million of medium term notes and $226 million of pollution control bonds outstanding issued through Jasper Co. Indiana. Columbia Gas of Massachusetts (aka Bay State Gas) had $40 million of notes outstanding (not rated by Fitch). All NI subsidiaries are expected to share a five-year $1.5 billion revolver at NIF that carries a 70% debt to cap financial covenant.

KEY ASSUMPTIONS
--Approximately $1.4 billion of capex annually from 2016 to 2020 ($400 million electric and approximately $1 billion gas);
--Reasonable amount of equity issuance;
--Dividend payout ratio approximately 60%;
--2014 bonus depreciation;
--Existing recovery mechanisms at the gas and electric utilities continue to take effect throughout the projection period.

RATING SENSITIVITIES
Positive: Future developments that may, individually or collectively, lead to a positive rating action include:
--Reduced regulatory risk with expanded revenue tracking or recovery mechanisms;
--Higher visibility for adjusted debt to EBITDAR to sustain below 4.75x.

Negative: Future developments that may, individually or collectively, lead to stabilization of the ratings at the current rating level include:
--Material adverse changes in the regulatory construct;
--Low probability to achieve adjusted debt to EBITDAR below 4.75x.

FULL LIST OF RATING ACTIONS

Fitch has affirmed the following ratings with a Positive Outlook:

NiSource Inc.

--IDR at 'BBB-';
--Short-term IDR at 'F3'.

NiSource Finance Corp.
--Senior unsecured at 'BBB-';
--Commercial paper at 'F3.

NiSource Capital Markets
--Senior unsecured at 'BBB-'.

Northern Indiana Public Service Co.
--IDR at 'BBB-';
--Senior unsecured and revenue bonds at 'BBB'.

Contact:

Primary Analyst
Julie Jiang
Director
+1-212-908-0708
Fitch Ratings, Inc.
33 Whitehall St.
New York, NY 10004

Secondary Analyst
Kathleen Connelly
Director
+1-212-908-0290

Committee Chairperson
Shalini Mahajan, CFA
Managing Director
+1-212-908-0351

Date of Relevant Rating Committee: June 17, 2015

Additional information is available on www.fitchratings.com

FitchRatings

Corporates

Utilities, Power & Gas / U.S.A.

NiSource, Inc.

And NiSource Finance Corp. and NiSource Capital Markets

Full Rating Report

Ratings

NiSource, Inc.

Long-Term IDR	BBB–
Short-Term IDR	F3

NiSource Finance Corp.

Senior Unsecured	BBB–
Commercial Paper	F3

NiSource Capital Markets, Inc.

Senior Unsecured	BBB–

IDR – Issuer Default Rating.

Rating Outlook

Positive

Financial Data

NiSource, Inc.

($ Mil.)	2Q15	2014
Adjusted Revenue	6,134	6,471
Operating EBITDAR	1,823	1,859
CFFO	1,779	1,320
Total Adjusted Debt	9,577	10,091
Total Capitalization	16,941	16,175
Capex/ Depreciation (%)	3.4	3.4
FFO Fixed-Charge Coverage (x)	4.0	3.8
FFO-Adjusted Leverage (x)	4.6	5.1
Total Adjusted Debt/EBITDAR (x)	5.3	5.4

Related Research

Fitch Affirms NiSource; Revises Outlook to Positive (June 2015)

Analysts

Julie Jiang
+1 212 908-0708
julie.jiang@fitchratings.com

Kathleen Connelly
+1 212 908-0290
kathleen.connelly@fitchratings.com

Key Rating Drivers

Low Business Risks: NiSource, Inc.'s (NI) ratings reflect its lower operating risk as a fully regulated utility holding company after spinoff, with a geographically diverse mix of regulated gas and electric utilities in seven states. Other considerations include the long-term financial impact of aggressive gas system modernization programs and electric environmental capex, with a substantial portion of recoveries expected to be received through tracking mechanisms.

Positive Outlook: Although NI's leverage ratios will continue to be elevated in the intermediate term due to legacy debt and capex, reduced business risks could outweigh high leverage. The Positive Outlook also embeds Fitch Ratings' expectation that adjusted debt to EBITDAR will improve to the low- to mid-4x range toward the end of a five-year forecast period, through project completion and equity issuance.

Focus on Gas Investments: NI's gas and electric operations represent approximately 65% and 35% of the operating income, respectively. Fitch expects gas operations to account for a greater share of the total earnings as NI invests more than twice as much in its gas utilities as it does in its electric utility. Fitch views such a trend favorably, as the regulations governing the gas utilities are considered more supportive to credit and are not subject to stringent environmental mandates.

Large Capex: NI is undertaking a significant capex program — nearly $1.4 billion annually ($400 million electric and $1.0 billion gas), compared with $780 million in 2011 and $1 billion in 2012. Though Fitch views these rate base-accretive investments favorably, NI will need to issue debt and a small amount of equity, and its credit metrics could be pressured temporarily.

Pending Infrastructure Plan: The uncertainties surrounding Northern Indiana Public Service Company's (NIPSCO, BBB–/Positive) settlement of its infrastructure plan will not have material impact to NI's credit quality, in Fitch's view. The dispute focuses on the lack of definitive details of recoverable projects and does not reflect a change in regulatory supportiveness. The Indiana Utility Regulatory Commission (IURC) recently agreed to re-evaluate the settlement. Fitch believes the issue will be reasonably resolved and an updated plan will likely be filed after the recent rate case filing in October.

Rating Linkages: NI's and subsidiary NIPSCO's ratings and Outlooks are the same due to their close linkage. All utility operations depend on NI for financing needs and share a five-year $1.5 billion revolver at NiSource Finance (NIF).

Rating Sensitivities

Positive Rating Action: NI could be upgraded if there is high probability for adjusted debt to EBITDAR to sustain below 4.75x, through equity issuance, deleveraging, or reduced regulatory risks with expanded revenue tracking or recovery mechanisms.

Negative Rating Action: NI's Outlook could be revised to Stable without an upgrade if there is low probability to achieve adjusted debt to EBITDAR below 4.75x. NI's rating could be downgraded if material adverse changes in the regulatory construct occur and/or if debt to EBITDAR is above 5.5x on a sustained basis.

Financial Overview

Liquidity and Debt Structure

NI (through NIF) downsized its existing $2 billion revolving credit facility in December 2014 to $1.5 billion, effective at the completion of the spinoff of Columbia Pipeline Group on July 1, 2015. The amendment also extended its termination date to July 1, 2020, with two one-year extensions. The facility carries a 70% debt-to-capitalization financial covenant and includes limitations on liens and restrictions on asset sales. It is used to support NI's commercial paper program, letters of credit and for general corporate use. As of June 30, 2015, NI had no commercial paper outstanding and $30.9 million of stand-by letters of credit outstanding, $14.7 million of which was supported by the revolving credit facility.

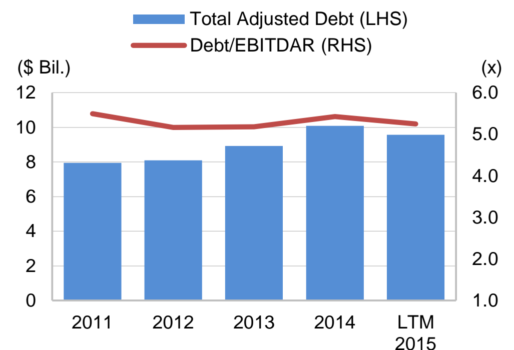
The regulated utilities' liquidity is also supported by NI's accounts receivable securitization programs. NI had a total of $141.8 million of borrowings under the programs at June 30, 2015.

Debt Maturities and Liquidity

($ Mil., As of June 30, 2015)	
2015	230
2016	422
2017	350
2018	476
Thereafter	4,980
Cash and Cash Equivalents	497
Undrawn Committed Facilities	2,124

Note: Debt maturities exclude Columbia Pipeline Group (CPG). Undrawn committed facilities include the accounts receivable securitization programs and exclude CPG credit facility.
Source: Company data, Fitch.

Total Debt and Leverage

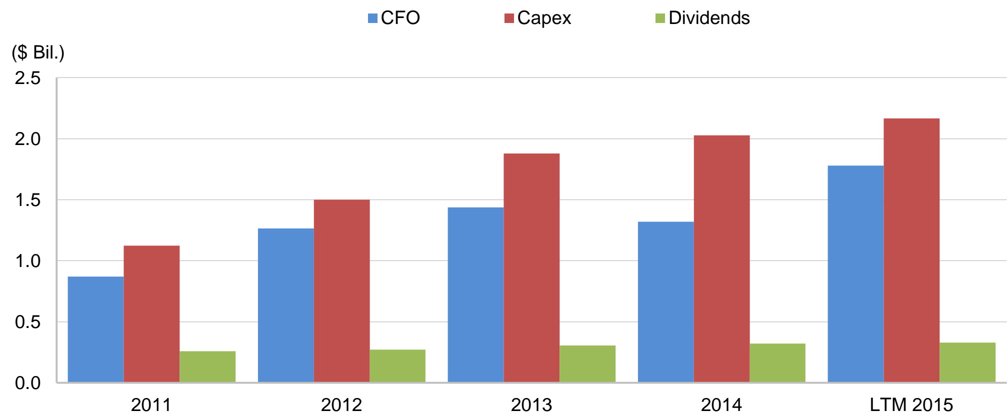


Source: Company data, Fitch.

Cash Flow Analysis

NI is undertaking a significant capex program across the gas and electric segments — nearly $1.4 billion combined annually ($400 million electric and $1.0 billion gas), compared with

CFO and Cash Use



Source: Company data, Fitch.

Related Criteria

Corporate Rating Methodology — Including Short-Term Ratings and Parent and Subsidiary Linkage (August 2015)

Parent and Subsidiary Rating Linkage (August 2015)

Recovery Ratings and Notching Criteria for Utilities (March 2015)

Rating U.S. Utilities, Power and Gas Companies (Sector Credit Factors) (March 2014)

$780 million in 2011 and $1 billion in 2012. The projects focus on system safety and modernization. An average of 75% of the capex is under pre-approved trackers or rate structure with little variability. Fitch views the ramp-up in these types of capex favorably, as they provide predictable and sustained earnings growth. However, they could temporarily pressure credit metrics. NI is expected to be cash flow negative throughout the 2015–2020 projection period — ranging from negative $400 million to $500 million — and will be largely financed by debt.

Peer and Sector Analysis

Peer Group

Issuer	Country
BBB+	
Dominion Resources, Inc.	U.S.
BBB	
CenterPoint Energy, Inc.	U.S.
BB+	
IPALCO Enterprises, Inc.	U.S.

Source: Fitch.

Issuer Rating History

Date	LT IDR (FC)	Outlook/ Watch
Sept. 30, 2015	BBB–	Positive
June 18, 2015	BBB–	Positive
April 24, 2015	BBB–	Stable
Sept. 29, 2014	BBB–	Stable
April 3, 2014	BBB–	Stable
Dec. 9, 2013	BBB–	Stable
Dec. 11, 2012	BBB–	Stable
Dec. 13, 2011	BBB–	Stable
Dec. 14, 2010	BBB–	Stable
Dec. 15, 2009	BBB–	Stable
Feb. 4, 2009	BBB–	Stable
May 14, 2008	BBB	Stable
July 10, 2007	BBB	Stable
March 31, 2006	BBB	Stable
Dec. 6, 2005	BBB	Stable
Sept. 21, 2005	BBB	Stable
June 30, 2003	BBB	Stable
Feb. 6, 2002	BBB	RWN
Dec. 6, 2001	BBB	Stable
Oct. 27, 2000	BBB+	Stable

LT IDR – Long-term Issuer Default Rating.
FC – Foreign currency.
RWN – Rating Watch Negative.
Source: Fitch.

Peer Group Analysis

($ Mil.)	NiSource Inc.	Dominion Resources, Inc.	CenterPoint Energy, Inc.	IPALCO Enterprises, Inc.
As of	6/30/15	6/30/15	6/30/15	6/30/15
IDR	BBB–	BBB+	BBB	BB+
Rating Outlook	Positive	Stable	Stable	Stable
Fundamental Ratios (x)				
Operating EBITDAR/(Gross Interest Expense + Rents)	3.5	4.8	4.4	3.4
FFO Fixed-Charge Coverage (x)	4.0	4.9	4.2	3.5
Total Adjusted Debt/Operating EBITDAR	5.3	5.3	3.9	5.3
FFO/Total Adjusted Debt (%)	22.0	19.5	24.6	19.7
FFO-Adjusted Leverage (x)	4.6	5.1	4.1	5.1
Common Dividend Payout (%)	78.7	73.1	70.7	130.4
Internal Cash/Capex (%)	67.2	53.6	67.4	36.9
Capex/Depreciation (%)	342.5	407.4	280.0	302.2
ROE (%)	6.7	16.7	13.2	22.9
Financial Information				
Revenue	6,134	12,149	8,110	1,277
Revenue Growth (%)	(2.7)	(7.0)	(9.6)	(1.6)
EBITDA	1,754	4,900	1,840	400
Operating EBITDA Margin (%)	26.5	40.5	31.5	26.7
FCF	(716)	(2,566)	(475)	(347)
Total Adjusted Debt with Equity Credit	9,577	26,574	7,237	2,125
Cash and Cash Equivalents	497	271	245	57
FFO	1,576	4,134	1,357	298
Capex	(2,167)	(5,532)	(1,459)	(550)

IDR – Issuer Default Rating.
Source: Company data, Fitch.

Key Rating Issues

Low Business Risk Mitigates High Leverage

NI's leverage before the spinoff was high among both utility and pipeline peer groups, primarily due to legacy debt related to the acquisition of Columbia Energy Group in November 2000 and investments in the pipeline business. Considering the debt reduction associated with the spinoff, NI's leverage ratio will continue to be elevated. However, Fitch believes NI's fully regulated business model allows it to bear relatively weak credit metrics for the rating and Outlook. Fitch projects NI's debt to EBITDAR to reach 4.5x in 2019 and 4.2x in 2020 and to continue improving beyond 2020 as capex programs complete and margin improves. Fitch has incorporated a certain amount of equity issuance in its projections, and believes management is committed to its rating and will likely issue equity if needed.

Supportive Regulations Despite NIPSCO Plan Uncertainty

NI's ratings and Outlook benefit from a geographically diverse mix of regulated gas and electric utilities in seven states with relatively transparent and supportive regulations. Gas utilities in all seven states have accelerated infrastructure trackers or expedited rate treatments, bad debt trackers and energy-efficiency programs.

Columbia Gas of Ohio, NI's largest gas utility by rate base, has revenue decoupling and fully fixed residential rates. Columbia Gas of Pennsylvania, the second largest gas utility, has weather normalization and is allowed to recover infrastructure and other costs through frequent rate filings utilizing a forward test year. Pennsylvania's Act 11 allows a gas utility to file a Distribution Service Improvement Charge and rate case with a fully forecast test year. Management estimates 80% of the recovery in the gas segment — including NIPSCO's gas operations — bears no volume risks from customer usage or weather patterns, compared with approximately 20%–40% in 2007.

NIPSCO's electric operations in Indiana have also seen improving regulations. Indiana legislation allows cost recovery of federally mandated requirements, including modernization or environmental capex. NIPSCO owns and operates 2.5 gigawatts (GW) of coal generation plants, which will be fully scrubbed by the end of 2015 and comply with sulfur dioxide, nitrogen oxide and Mercury and Air Toxics Standards rules. Indiana Senate Bill 560 was signed into law in 2013, and allows forward test years and provides cost recovery outside of base rate proceedings for gas and electric utility investments. The law specifically relates to transmission, distribution and storage projects undertaken for the purpose of safety, reliability, system modernization or economic development.

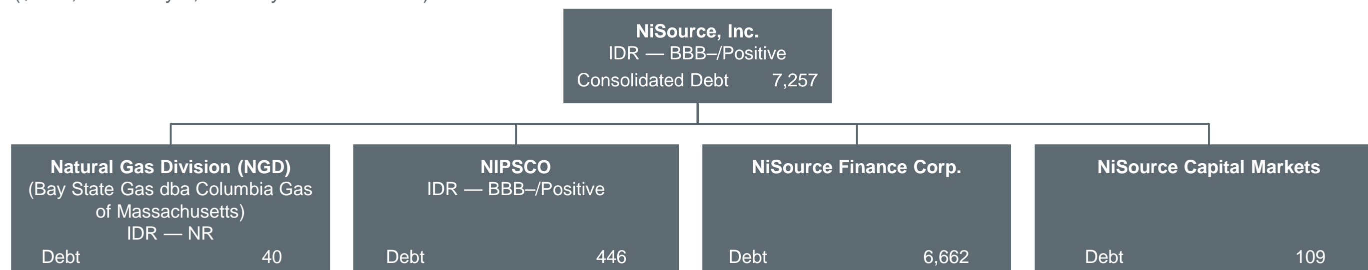
NIPSCO also has Federal Energy Regulatory Commission-approved forward looking rates, including construction work in progress and recovery of any potential abandonment costs, and the allowed ROE is 12.38% for its two Midcontinent Independent System Operator transmission projects (approximately $450 million).

Fitch believes the uncertainties surrounding NIPSCO's settlement of its infrastructure plan will not have a material impact on NI's credit quality. The dispute centers on the technicality of the filing and does not reflect adverse changes in the regulatory framework. Fitch believes the final resolution of the issue, such as filing a new seven-year plan after the recent rate case filing, will be supportive to NI's credit profile. The IURC agreed to reconsider the settlement agreement in October 2015.

Organizational Structure

Organizational and Debt Structure — NiSource, Inc.

($ Mil., As of July 1, 2015 by Fitch Estimate)



IDR – Issuer Default Rating. NR – Not rated.
Source: Fitch estimates.

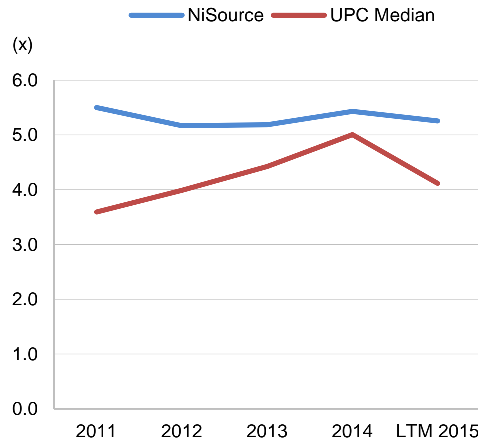
FitchRatings

Key Metrics

Definitions

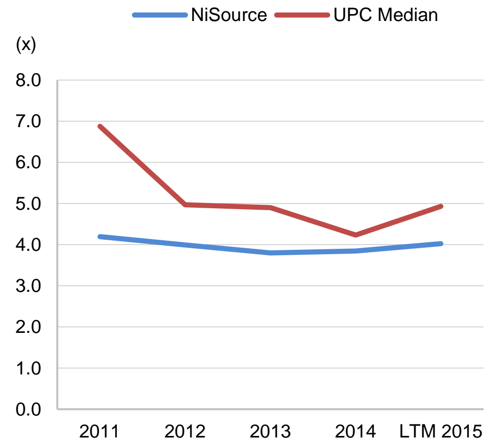
- Total Adjusted Debt/Op. EBITDAR: Total balance sheet adjusted for equity credit and off-balance sheet debt divided by operating EBITDAR.
- FFO Fixed-Charge Coverage: FFO plus gross interest minus interest received plus preferred dividends plus rental payments divided by gross interest plus preferred dividends plus rental payments.
- FFO-Adjusted Leverage: Gross debt plus lease adjustment minus equity credit for hybrid instruments plus preferred stock divided by FFO plus gross interest paid plus preferred dividends plus rental expense.

Total Adjusted Debt/Operating EBITDAR



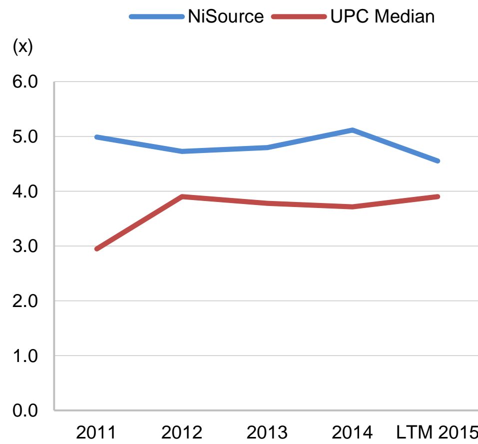
UPC – Utility parent company.
Source: Company data, Fitch.

FFO Fixed-Charge Coverage



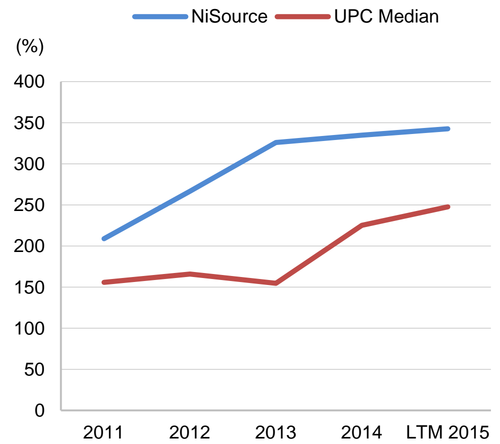
UPC – Utility parent company.
Source: Company data, Fitch.

FFO-Adjusted Leverage



UPC – Utility parent company.
Source: Company data, Fitch.

Capex/Depreciation



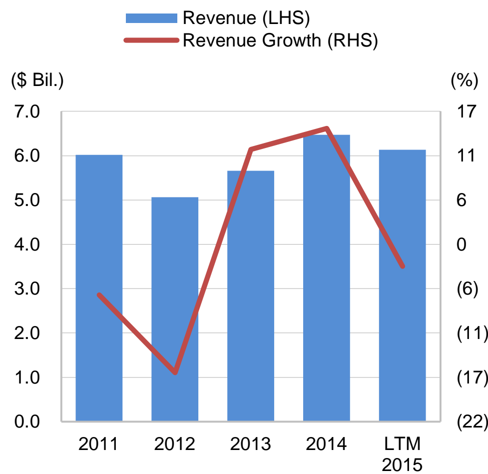
UPC – Utility parent company.
Source: Company data, Fitch.

Company Profile

NI is a utility holding company whose regulated subsidiaries provide natural gas and electricity to 4 million customers in Indiana, Ohio, Pennsylvania, Massachusetts, Virginia, Kentucky and Maryland. The rate bases of the gas and electric utilities were $5 billion and $3 billion, respectively, as of December 2014. The gas distribution segment accounts for approximately 65% of operating earnings and electric operations account for 35%. In 2014, 55% of NI's net revenue was derived from residential customers, 25% from commercial customers and 20% from industrial customers. NI's subsidiary NIPSCO has a total net generation capacity of 3.3 GW, 2.5 GW of which is from coal-fired generating plants.

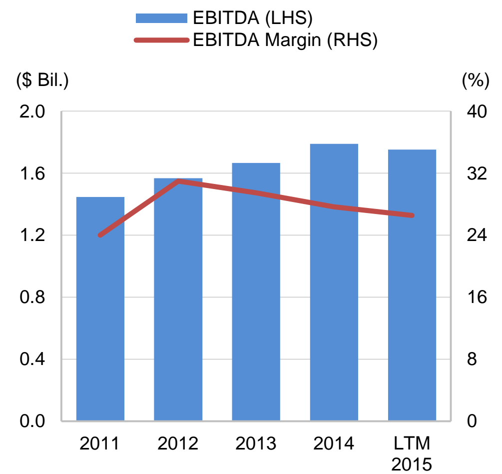
Business Trends

Revenue Dynamics



Source: Company data, Fitch.

EBITDA Dynamics



Source: Company data, Fitch.

Financial Summary — NiSource, Inc.

($ Mil., As of June 30, 2015; IDR: BBB–/Positive)	2011	2012	2013	2014	LTM 6/30/15
Fundamental Ratios					
Operating EBITDAR/(Gross Interest Expense + Rents) (x)	3.8	3.7	3.5	3.6	3.5
FFO Fixed-Charge Coverage (x)	4.2	4.0	3.8	3.8	4.0
Total Adjusted Debt/Operating EBITDAR (x)	5.5	5.2	5.2	5.4	5.3
FFO/Total Adjusted Debt (%)	20.0	21.2	20.9	19.6	22.0
FFO-Adjusted Leverage (x)	5.0	4.7	4.8	5.1	4.6
Common Dividend Payout (%)	86.3	65.6	57.5	60.6	78.7
Internal Cash/Capex (%)	54.4	66.2	60.2	49.2	67.2
Capex/Depreciation (%)	209.1	266.7	325.8	335.0	342.5
ROE (%)	6.0	7.9	9.3	8.8	6.7
Profitability					
Revenues	6,019	5,061	5,657	6,471	6,134
Revenue Growth (%)	(6.3)	(15.9)	11.8	14.4	(2.7)
Net Revenues	3,463	3,519	3,841	4,246	4,318
Operating and Maintenance Expense	1,722	1,663	1,874	2,136	2,237
Operating EBITDA	1,446	1,568	1,666	1,790	1,754
Operating EBITDAR	1,446	1,568	1,722	1,859	1,823
Depreciation and Amortization Expense	538	562	577	606	633
Operating EBIT	908	1,006	1,089	1,184	1,121
Gross Interest Expense	380	429	434	444	454
Net Income for Common	299	416	532	530	418
Operating Maintenance Expense % of Net Revenues	49.7	47.3	48.8	50.3	51.8
Operating EBIT % of Net Revenues	26.2	28.6	28.4	27.9	26.0
Cash Flow					
Cash Flow from Operations	870	1,265	1,437	1,320	1,779
Change in Working Capital	(344)	(20)	65	(141)	199
Funds from Operations	1,214	1,285	1,372	1,461	1,576
Dividends	(258)	(273)	(306)	(321)	(329)
Capex	(1,125)	(1,499)	(1,880)	(2,029)	(2,167)
FCF	**(513)**	**(507)**	**(749)**	**(1,030)**	**(716)**
Net Other Investment Cash Flow	(33)	48	(30)	(101)	(69)
Net Change in Debt	580	78	719	1,106	191
Net Equity Proceeds	21	374	36	20	1,175
Capital Structure					
Short-Term Debt	1,359	777	699	1,577	162
Total Long-Term Debt	6,594	7,326	8,135	8,423	9,324
Total Debt with Equity Credit	**7,953**	**8,103**	**8,834**	**9,999**	**9,486**
Total Adjusted Debt with Equity Credit	7,953	8,103	8,926	10,091	9,577
Total Hybrid Equity and Minority Interest	—	—	—	—	950
Total Common Shareholders' Equity	4,997	5,554	5,886	6,175	6,506
Total Capital	**12,950**	**13,657**	**14,720**	**16,175**	**16,941**
Total Debt/Total Capital (%)	61.4	59.3	60.0	61.8	56.0
Total Hybrid Equity and Minority Interest/Total Capital (%)	—	—	—	—	5.6
Common Equity/Total Capital (%)	38.6	40.7	40.0	38.2	38.4

IDR – Issuer Default Rating. Note: Data includes Columbia Pipeline Group.
Source: Company data, Fitch.

The ratings above were solicited by, or on behalf of, the issuer, and therefore, Fitch has been compensated for the provision of the ratings.

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CREDIT OPINION
13 June 2016

Update

Rate this Research

Contacts

Lesley Ritter 212-553-1607
Analyst
lesley.ritter@moodys.com

Michael G. Haggarty 212-553-7172
Associate Managing Director
michael.haggarty@moodys.com

William L. Hess 212-553-3837
MD-Utilities
william.hess@moodys.com

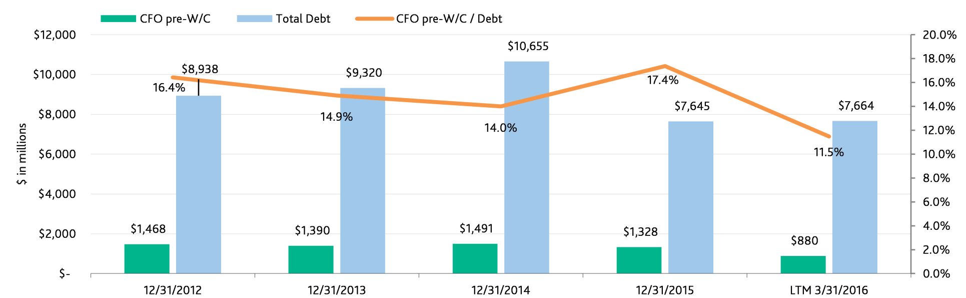
NiSource Inc.

A regulated utility holding company

Summary Rating Rationale

NiSource Inc.'s (NiSource) Baa2 rating (for its guaranteed finance subsidiary NiSource Finance Corporation) reflects the credit supportiveness and diversity of its multiple regulatory jurisdictions that allow the company to generate stable and predictable operating cash flows, the low business risk nature of its operations (approximately 68% of utility operating earnings are generated by natural gas local distribution companies (LDCs)), as well as its broad geographic footprint and scale (approximately 4 million utility customers across seven states). Together, these help to mitigate a weak financial profile as the company manages elevated debt levels while executing on a sizeable capital investment program. We anticipate a ratio of cash flow to debt in the low-teens' range over the next three to five years.

Exhibit 1
Historical CFO Pre W/C, Total Debt and CFO Pre W/C to Debt



Source: Moody's Financial Metrics

Credit Strengths

» Operations in jurisdictions with attractive cost recovery mechanisms

» Regulated utility assets carry low business risk

» Stability of cash flows underpinned by supportive regulatory constructs that largely offset high leverage

Credit Challenges

» Persistently high debt balance

» Elevated investment spending

Rating Outlook

The stable outlook reflects our expectation that the modest decline in NiSource's financial profile due to its corporate separation will be temporary. We expect a debt to capitalization ratio of approximately 50% as well as a decline in its cash flow to debt to the 12-13% range before the latter slowly rises closer to the low-teens range towards the end of the decade. The stable outlook also reflects our view that NiSource's regulated utility capital expenditure plans will be financed in a balanced manner. The outlook also takes into account the credit supportiveness of NiSource's regulatory environments, the low business risk associated with its LDC operations, and the scale and scope of its footprint, that together act to mitigate financial ratios that will be temporarily weak for the rating.

Factors that Could Lead to an Upgrade

» Further improvement in the utility regulatory environment

» A material and sustained increase in the company's credit metrics with cash flow to debt in the high teens and interest coverage in excess of 4.0x

Factors that Could Lead to a Downgrade

» A decline in the credit supportiveness of NiSource's regulatory environments

» An adverse change in the company's business mix or corporate structure such that its business risk profile deteriorates

» Debt coverage and debt to capitalization fall below 12% or rise above 55%, respectively, on a sustained basis

Key Indicators

Exhibit 2

KEY INDICATORS [1]

NiSource Inc.

	12/31/2012	12/31/2013	12/31/2014	12/31/2015	3/31/2016(L)
CFO pre-WC + Interest / Interest	4.2x	4.1x	4.7x	4.2x	3.1x
CFO pre-WC / Debt	16.4%	14.9%	14.0%	17.4%	11.5%
CFO pre-WC – Dividends / Debt	13.4%	11.6%	11.0%	13.9%	8.5%
Debt / Capitalization	51.2%	50.4%	56.1%	55.4%	54.9%

[1]All ratios are based on 'Adjusted' financial data and incorporate Moody's Global Standard Adjustments for Non-Financial Corporations.
Source: Moody's Financial Metrics

Detailed Rating Considerations

PERSISTENTLY HIGH DEBT BALANCE AND ELEVATED INVESTMENT SPENDING WEIGH ON FINANCIAL PROFILE

NiSource's rating is constrained by its weak financial profile, primarily relating to its elevated debt levels which appear unlikely to change for the foreseeable future and will continue to weigh on its debt coverage metrics.

The extensive capital investment projects at its utilities, estimated at about $1.4 billion per year through 2020 and equivalent to 2.5x 2015 depreciation, will place added pressure on the company's financial profile. As a result, we anticipate that NiSource's debt coverage metrics will decline from their historical levels to the 12-13% range before returning to the mid-teens towards the end of the decade, once new projects begin generating sufficient cash flows to offset the incremental leverage used to partially fund these capital projects.

Given NiSource's existing debt balance, we expect the company to adopt a conservative approach to financing its capital investments, including equity issuances, as necessary to avoid further erosion of its debt coverage and debt to capitalization ratios.

STABILITY OF CASH FLOWS UNDERPINNED BY SUPPORTIVE REGULATORY CONSTRUCT LARGELY OFFSETS HIGH LEVERAGE

This publication does not announce a credit rating action. For any credit ratings referenced in this publication, please see the ratings tab on the issuer/entity page on www.moodys.com for the most updated credit rating action information and rating history.

The state regulators overseeing NiSource's utilities are generally credit supportive. Each LDC benefits from decoupling mechanisms and/or weather normalization adjustments which reduce earnings volatility. In addition, NiSource has access to a variety of tracker mechanisms across its different jurisdictions to cover its ongoing infrastructure replacement program, that provide for timely recovery of its sizeable infrastructure investment program. Similarly, NiSource's electric segment benefits from a broad array of tracker mechanisms providing for timely recovery of operating expenses as well as environmental investments.

The company's investments across all of its jurisdictions, as well as higher operations and maintenance expenditures to comply with pipeline safety regulations, are driving a busy 2016 regulatory calendar. After completing three general rate cases in 2015 that added $90 million in incremental annual revenues as well as some other smaller regulatory tracker filings, NiSource expects to secure final general rate case orders on three filings in 2016, potentially adding $134 million in annual revenues, assuming the regulators grant the full ask.

In addition, NIPSCO recently filed a stipulation and settlement agreement for its revised seven-year electric rate plan outlining $1.25 billion of infrastructure investments. The plan was filed according to requirements outlined in Senate Bill 560 that provides for timely recovery of safety, reliability and modernization capex under a tracker mechanism. A decision is expected in the third quarter of 2016.

REGULATED UTILITY ASSETS ARE LOW RISK

NiSource's seven LDCs represent about 68% of operating income (based on FYE 2015), while its vertically integrated electric utility segment makes up the difference.

With no exposure to the risks associated with owning power-generation assets, LDCs carry lower business risk than their vertically integrated electric utility counterparts. Furthermore, the size and broad geographic footprint of NiSource's LDC operations offer regulatory diversity and provide a natural hedge against material exposure to a single jurisdiction.

NiSource's electric segment is inherently riskier than the LDC business. In addition to its exposure to the risks associated with generation assets, unlike its LDC counterparts, its operations are concentrated in a single, highly industrialized market territory. About fifty-five percent of the company's retail electric sales volumes are derived from industrial customers, leaving it particularly sensitive to economic cycles. Also, the electric segment's rate structure does not have the decoupling mechanisms many NiSource's LDCs have.

Still, Indiana's regulatory environment is generally favorable from a credit standpoint and provides the company's electric segment with an attractive suite of cost recovery mechanisms that cover most of its operating and capital expenses. Additionally, the company is on schedule to complete the environmental retrofits of its generation fleet on time and on budget. Furthermore, its latest Integrated Resource Plan, released in 2014, does not envision the need for new power generation investment for the foreseeable future, a credit positive since it further supports the relative stability of NiSource's electric segment.

Liquidity Analysis

NiSource's liquidity is adequate and is supported by a $1.5 billion revolving credit facility maturing in July 2020. The revolver backs a $1.5 billion commercial paper program and provides funds for ongoing working capital needs. Terms of the facility allow for reliable access to funds by not requiring the company to represent and warrant to any material adverse change at each borrowing. The sole financial covenant is a maximum debt-to-capitalization ratio of 70% which the company satisfies as of 31 March 2016, with a debt to capitalization ratio of 64.4%.

NiSource also maintains three separate accounts receivables securitization programs totaling $515 million at its LDCs ($385 million outstanding as of 31 March 2016). The programs are renewed annually. As of 31 March 2016, NiSource had about $1.0 billion of available capacity under its revolver, after giving effect to $460 million of commercial paper outstanding and $15 million of LCs, as well as about $24 million of cash on hand. NiSource's next material debt maturity is scheduled for September 2017 when $210 million of notes come due.

For LTM 31 March 2016, NiSource generated $1.2 billion in operating cash flow, invested $1.4 billion in capital expenditures and made $231 million in dividend distributions to their common shareholders, resulting in a negative free cash flow position of $494 million. NiSource funded the cash shortfall by issuing short-term debt. Going forward, we expect NiSource to remain free cash flow negative

as it executes on its sizeable capital expenditure plan and anticipate that it will meet any cash shortfall through a balanced mix of debt and equity.

Notching Considerations

NiSource's operating subsidiary NIPSCO is rated one notch above NiSource to reflect its default probability and the structural seniority of its debt to substantially all of the parent guaranteed debt at NiSource Finance Corp. Subsidiary Bay State's debt is guaranteed by NiSource and consequently has the same rating as NiSource.

As shown in the methodology grid, the grid indicates a rating of Baa1, which does not reflect the structural subordination that causes the actual parent rating to be Baa2. Ratings within the NiSource family are notched closely partly because of the company's practice to centrally manage its subsidiaries' cash flow in a corporate money pool and consolidating its debt financing at its guaranteed financing subsidiary NiSource Finance Corp.

Corporate Profile

NiSource Inc. (Baa2, senior unsecured for its guaranteed financing vehicle, NiSource Finance Corp) is a utility holding company with a portfolio of regulated utility subsidiaries. NiSource owns one of the largest LDC systems in the US, with operations in Ohio, Indiana, Pennsylvania, Virginia, Massachusetts, Kentucky, and Maryland with over 3.4 million customers, as well as a mid-sized vertically integrated electric utility in Indiana. The LDCs account for about 68% of the company's consolidated operating earnings, with the balance coming from its electric utility. Two of NiSource's utility subsidiaries are rated: Bay State Gas Company (Bay State Gas, doing business as Columbia Gas of Massachusetts, Baa2 senior unsecured, stable) and Northern Indiana Public Service Company (NIPSCO, Baa1 senior unsecured, stable).

Rating Methodology and Scorecard Factors

Exhibit 3

Rating Factors				
NiSource Inc.				
Regulated Electric and Gas Utilities Industry Grid [1][2]	**Current LTM 3/31/2016**		**Moody's 12-18 Month Forward View As of Date Published [3]**	
Factor 1 : Regulatory Framework (25%)	**Measure**	**Score**	**Measure**	**Score**
a) Legislative and Judicial Underpinnings of the Regulatory Framework	A	A	A	A
b) Consistency and Predictability of Regulation	A	A	A	A
Factor 2 : Ability to Recover Costs and Earn Returns (25%)				
a) Timeliness of Recovery of Operating and Capital Costs	A	A	A	A
b) Sufficiency of Rates and Returns	A	A	A	A
Factor 3 : Diversification (10%)				
a) Market Position	A	A	A	A
b) Generation and Fuel Diversity	Ba	Ba	Ba	Ba
Factor 4 : Financial Strength (40%)				
a) CFO pre-WC + Interest / Interest (3 Year Avg)	4.2x	Baa	3x - 4x	Baa
b) CFO pre-WC / Debt (3 Year Avg)	15.4%	Baa	11% - 14%	Baa
c) CFO pre-WC – Dividends / Debt (3 Year Avg)	12.1%	Baa	9% - 12%	Baa
d) Debt / Capitalization (3 Year Avg)	49.5%	A	50% - 55%	Baa
Rating:				
Grid-Indicated Rating Before Notching Adjustment		A3		Baa1
HoldCo Structural Subordination Notching	0	0	0	0
a) Indicated Rating from Grid		A3		Baa1
b) Actual Rating Assigned		Baa2		Baa2

[1]All ratios are based on 'Adjusted' financial data and incorporate Moody's Global Standard Adjustments for Non-Financial Corporations.
[2]As of 3/31/2016(L)
[3[This represents Moody's forward view; not the view of the issuer; and unless noted in the text, does not incorporate significant acquisitions and divestitures.
Source: Moody's Financial Metrics

Ratings

Exhibit 4

Category	Moody's Rating
NISOURCE INC.	
Outlook	Stable
Pref. Shelf	(P)Ba1
NISOURCE FINANCE CORPORATION	
Outlook	Stable
Issuer Rating	Baa2
Sr Unsec Bank Credit Facility	Baa2
Senior Unsecured	Baa2
Bkd Commercial Paper	P-2
NORTHERN INDIANA PUBLIC SERVICE COMPANY	
Outlook	Stable
Issuer Rating	Baa1
Senior Unsecured	Baa1
NISOURCE CAPITAL MARKETS, INC.	
Outlook	Stable
Bkd Senior Unsecured	Baa2
BAY STATE GAS COMPANY	
Outlook	Stable
Senior Unsecured	Baa2

Source: Moody's Investors Service

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REPORT NUMBER 1030003

MOODY'S
INVESTORS SERVICE

FITCH UPGRADES NI AND NIPSCO'S IDR TO 'BBB'; OUTLOOK STABLE

Fitch Ratings-New York-17 June 2016: Fitch Ratings has upgraded the Long-Term Issuer Default Ratings (IDRs) of NiSource Inc. (NI) and Northern Indiana Public Service Company (NIPSCO) to 'BBB' from 'BBB-'. The Rating Outlook is Stable.

A complete list of rating actions is provided at the end of this release.

The rating and Outlook reflect NI's low operating risk as a fully regulated utility holding company with supportive regulation and improved business risk profile in recent years. The ratings also consider NI's robust capex program and management's willingness to issue equity to preserve credit quality, if needed. Fitch estimates that NI's leverage ratios as measured by debt-to-operating EBITDAR will remain elevated in the intermediate term, due to its large capex program and legacy debt, before improving to high-4x by 2020.

KEY RATING DRIVERS

Low Business Risk

NI's fully regulated, relatively low-risk business model is supported by stable cash flows and earnings from a geographically diverse mix of regulated gas and electric utilities in seven states. Gas distribution and electric operations represent 61% and 39%, respectively, of the total rate base. Over time, Fitch expects gas operations to represent a greater share of the rate base as the company invests more than twice as much capex in its gas utilities as it does in its electric segment. Fitch considers this trend to be positive as NI's gas distribution utilities benefit from more supportive regulations with less exposure to stringent environmental mandates.

Supportive Regulation

The ratings and Stable Outlook consider supportive regulatory frameworks across NI's operating utilities' service territories. Balanced regulation is particularly important from a credit perspective in light of NI's aggressive gas and electric infrastructure modernization programs and high debt leverage. Approximately 77% of capex investment in the next several years is expected to be recovered through trackers and other cost-recovery mechanisms.

Most of NI's gas utilities have decoupling, straight fixed variable rates and/or weather normalization mechanisms. All of NI's gas utilities use infrastructure trackers on a regular basis except Pennsylvania.

In Indiana, the Transmission, Distribution and Storage System Improvement Charge (TDSIC) statute provides for cost recovery outside of general rate case proceedings for gas or electric safety, reliability and modernization and allows pre-approval of a seven-year plan of eligible investments. If approved, up to 80% of eligible costs can be recovered using semi-annual trackers. NIPSCO's two MISO transmission projects benefit from constructive FERC regulation, including forward-looking rates and CWIP recovery.

NIPSCO Settlements Constructive

Fitch views recent developments in NIPSCO's pending rate proceedings favorably.

NIPSCO reached a settlement in March 2016 for a seven-year electric TDSIC plan that includes $1.25 billion of eligible investments. A final order is expected in the third quarter of 2016. If the settlement is approved by the Indiana Utility Regulatory Commission (IURC), NIPSCO expects to start recovery based on TDSIC's semi-annual rate adjustment mechanism.

NIPSCO's gas segment is in the midst of an $800 million gas infrastructure modernization program. On March 30, 2016, the IURC approved the semi-annual tracker (TDSIC-3) that NIPSCO filed in August 2015, including approximately $74 million of investments through mid-2015. Rates took effect on April 1, 2016. NIPSCO submitted its latest semi-annual tracker TDSIC-4 update with the IURC on Feb. 29, 2016.

On Feb. 19, 2016, NIPSCO reached a settlement of its electric base rate case that, if approved by the IURC, would allow a revenue increase of $72.5 million, based on an authorized ROE of 9.975% before certain riders. The rate increase under the terms of the settlement represents approximately 58% of NIPSCO's rate increase request. A final order is expected in the third quarter of 2016.

High Capex Pressures Credit Metrics

NI's capex began to ramp up in 2012. From 2012 to 2015, capex averaged $1.23 billion per year compared to $709 million per year from 2008 to 2011. NI capex is expected to average $1.45 billion per year 2016 - 2021.

Fitch projects that NI's debt-to-operating EBITDAR will continue to be over 5x through 2019 and decline to high-4x in 2020. FFO adjusted leverage is expected to decline to high-4x in 2020 from 5.3x in 2016 and FFO fixed charge coverage to improve from 3.4x to 4x. Fitch's projection incorporates bonus depreciation benefits and a certain amount of equity issuance.

Rating Linkages

NI and NIPSCO's IDRs will continue to be equalized reflecting strong operational, strategic and financial linkage. NI finances substantially all of its utility operations through NiSource Finance (NIF) with guarantee from NI. All NI subsidiaries share a five-year $1.5 billion revolver at NIF.

KEY ASSUMPTIONS

--An average of $1.45 billion capex annually from 2016 to 2021;
--Dividend payout ratio averages approximately 63%;
--Balanced regulation and continued utilization of jurisdictional cost-recovery mechanisms for NI's gas and electric utility subsidiaries throughout the projection period.

RATING SENSITIVITIES
Positive: Future developments that may, individually or collectively, lead to a positive rating action include:
--NI and NIPSCO could be upgraded if adjusted debt-to-operating EBITDAR is expected to sustain below 4x.

Negative: Future developments that may, individually or collectively, lead to a negative rating action include:
--Material adverse changes in NI's regulatory construct;
--Negative rating pressure could mount if adjusted debt to operating EBITDAR sustains below 5.25x with low probability to recover.

Fitch has upgraded following ratings with a Stable Outlook:

NiSource Inc.
--LT IDR to 'BBB' from 'BBB-'.

NiSource Finance Corp.
--Senior unsecured notes to 'BBB' from 'BBB-'.

NiSource Capital Markets, Inc.
--Senior unsecured notes to 'BBB' from 'BBB-'.

Northern Indiana Public Service Co.
--LT IDR to 'BBB' from 'BBB-';
--Senior unsecured and revenue bonds to 'BBB+' from 'BBB'.

Fitch has affirmed following ratings with a Stable Outlook:

NiSource Inc.
--Short-term IDR at 'F3'.

NiSource Finance Corp.
--Commercial paper at 'F3'.

Contact:

Primary Analyst
Julie Jiang
Director
+1-212-908-0708
Fitch Ratings, Inc.
33 Whitehall St.
New York, NY 10004

Secondary Analyst
Maude Trembley
Director
+1-312-368-3203

Committee Chairperson
Philip Smyth, CFA
Senior Director
+1-212-908-0531

Media Relations: Alyssa Castelli, New York, Tel: +1 (212) 908 0540, Email: alyssa.castelli@fitchratings.com.

Date of Relevant Rating Committee: June 16, 2016

Additional information is available on www.fitchratings.com

Applicable Criteria

Corporate Rating Methodology - Including Short-Term Ratings and Parent and Subsidiary Linkage (pub. 17 Aug 2015)
https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=869362

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COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

27. Provide Columbia Gas of Kentucky's return on common equity for the years 2010 through 2015. Provide all supporting work papers and documentation.

Response:

Please refer to AG 1-27 Attachment A to this response. Please note that the calculation of ROE is based on actual unadjusted net income and common equity as shown in Columbia's financial statements and, therefore, includes items that are non-utility in nature and, accordingly, are not included in the determination of a revenue requirement for the purposes of developing base rates.

Columbia Gas of Kentucky, Inc.

Net Income & Common Equity

Line No.	Month / Year	Net Income (Monthly)	Common Equity (Monthly)	Net Income Twelve Months Ended	Common Equity 13 Month Average	Return on 13 Month Average Equity
		$	$	$	$	%
1	December 2009		88,638,628			
2	January 2010	3,483,704	92,122,332			
3	February	2,516,984	94,639,316			
4	March	1,523,572	94,162,889			
5	April	230,133	94,393,022			
6	May	138,854	94,531,876			
7	June	(286,609)	91,245,268			
8	July	(169,200)	91,076,068			
9	August	14,606	91,090,674			
10	September	(212,872)	87,877,803			
11	October	32,631	87,977,370			
12	November	1,519,625	89,498,369			
13	December 2010	1,898,731	89,397,100	10,690,159	91,280,824	11.71%
14	January 2011	3,030,543	92,427,643	10,236,998	91,572,287	11.18%
15	February	2,462,995	94,890,638	10,183,009	91,785,234	11.09%
16	March	1,505,119	94,395,758	10,164,556	91,766,498	11.08%
17	April	480,047	94,875,805	10,414,470	91,821,338	11.34%
18	May	174,776	95,050,581	10,450,392	91,871,919	11.37%
19	June	(281,263)	92,769,319	10,455,738	91,736,338	11.40%
20	July	(293,231)	92,476,088	10,331,707	91,831,017	11.25%
21	August	266,668	92,742,756	10,583,769	91,959,223	11.51%
22	September	(98,668)	89,644,089	10,697,973	91,847,948	11.65%
23	October	327,334	89,971,423	10,992,676	92,008,995	11.95%
24	November	1,534,439	88,745,722	11,007,490	92,068,099	11.96%
25	December 2011	1,745,500	90,341,542	10,854,259	92,132,959	11.78%
26	January 2012	2,252,920	92,594,462	10,076,636	92,378,910	10.91%
27	February	2,454,134	95,048,596	10,067,775	92,580,521	10.87%
28	March	1,184,757	94,233,354	9,747,413	92,529,961	10.53%
29	April	20,692	94,254,046	9,288,058	92,519,060	10.04%
30	May	(95,245)	94,158,801	9,018,037	92,463,906	9.75%
31	June	(232,648)	92,926,154	9,066,652	92,300,489	9.82%
32	July	(183,351)	92,742,803	9,176,532	92,298,449	9.94%
33	August	(365,560)	92,377,243	8,544,304	92,290,845	9.26%
34	September	(160,237)	90,217,007	8,482,735	92,096,557	9.21%
35	October	456,000	90,673,007	8,611,401	92,175,705	9.34%
36	November	971,858	91,644,865	8,048,820	92,304,431	8.72%
37	December 2012	2,212,401	91,857,267	8,515,721	92,543,781	9.20%
38	January 2013	2,896,803	94,754,070	9,159,604	92,883,206	9.86%
39	February	2,177,050	96,931,120	8,882,520	93,216,795	9.53%
40	March	619,504	96,550,625	8,317,267	93,332,336	8.91%
41	April	898,827	97,449,452	9,195,402	93,579,728	9.83%
42	May	(19,046)	97,430,406	9,271,601	93,824,063	9.88%

Columbia Gas of Kentucky, Inc.

Net Income & Common Equity

Line No.	Month / Year	Net Income (Monthly)	Common Equity (Monthly)	Net Income Twelve Months Ended	Common Equity 13 Month Average	Return on 13 Month Average Equity
		$	$	$	$	%
43	June	(194,282)	97,236,124	9,309,967	94,060,780	9.90%
44	July	(172,478)	97,063,646	9,320,840	94,379,049	9.88%
45	August	(325,206)	96,738,440	9,361,194	94,686,406	9.89%
46	September	(190,486)	96,547,954	9,330,945	95,007,229	9.82%
47	October	624,672	97,264,596	9,499,617	95,549,352	9.94%
48	November	1,690,986	98,955,582	10,218,745	96,186,473	10.62%
49	December 2013	2,430,240	100,385,824	10,436,584	96,858,854	10.78%
50	January 2014	3,592,792	103,978,616	11,132,573	97,791,266	11.38%
51	February	3,157,330	107,135,946	12,112,853	98,743,718	12.27%
52	March	2,068,644	109,204,590	13,561,993	99,687,831	13.60%
53	April	871,755	110,076,388	13,534,921	100,728,274	13.44%
54	May	68,069	110,144,457	13,622,036	101,704,813	13.39%
55	June	(411,131)	107,733,325	13,405,187	102,497,345	13.08%
56	July	(244,241)	107,489,084	13,333,423	103,286,034	12.91%
57	August	(313,272)	107,175,812	13,345,357	104,063,893	12.82%
58	September	(701,390)	106,474,422	12,834,453	104,812,815	12.25%
59	October	(111,639)	106,405,449	12,098,142	105,571,084	11.46%
60	November	1,732,119	108,137,678	12,139,276	106,407,475	11.41%
61	December 2014	2,362,936	110,500,615	12,071,972	107,295,554	11.25%
62	January 2015	3,543,415	114,044,030	12,022,595	108,346,186	11.10%
63	February	2,784,933	116,828,963	11,650,198	109,334,674	10.66%
64	March	1,859,555	117,188,518	11,441,109	110,107,949	10.39%
65	April	992,987	118,181,505	11,562,341	110,798,480	10.44%
66	May	(84,535)	118,105,590	11,409,738	111,416,111	10.24%
67	June	(962,864)	116,424,591	10,858,005	111,899,199	9.70%
68	July	(85,857)	116,338,734	11,016,390	112,561,153	9.79%
69	August	(142,329)	116,196,405	11,187,333	113,230,947	9.88%
70	September	(150,629)	113,543,774	11,738,095	113,720,790	10.32%
71	October	371,453	113,915,228	12,221,187	114,293,160	10.69%
72	November	1,097,596	115,012,824	11,586,664	114,955,266	10.08%
73	December 2015	1,897,924	114,423,317	11,121,651	115,438,776	9.63%

**COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016**

28. Provide all work papers and supporting documentation for Columbia's requested cost of long-term debt. Provide all spreadsheets with cell formulas intact.

Response:

Please refer to Columbia's response to the KY PSC Staff Data Request PSC 2-44.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

29. Provide all work papers and supporting documentation for Columbia's requested cost of short-term debt of 2.5%. Provide all spreadsheets with cell formulas intact.

Response:

The basis of Columbia's short-term borrowings is 1 month LIBOR plus an applicable rate as included in NiSource's revolving credit agreement. Please refer to AG 1-29 Attachment A, filed in this docket as CKY_R_AGDR1_NUM29_Attachment_A_072216, for the calculation and AG 1-29 Attachment B for the pricing grid included within the revolving credit agreement.

Short Term Borrowing Rate Calculation

Line No.	Date	1 mo. LIBOR Rate	Source
1	12/31/2016	1.130	Forward Rate per Bloomberg on 8/26/2015
2	3/31/2017	1.222	Forward Rate per Bloomberg on 8/26/2015
3	6/30/2017	1.431	Forward Rate per Bloomberg on 8/26/2015
4	9/30/2017	1.527	Forward Rate per Bloomberg on 8/26/2015
5	12/31/2017	1.717	Forward Rate per Bloomberg on 8/26/2015
6	Average	1.405	Average of lines 1 - 6
7	Revolver Eurodollar BBB+ Cost	1.075	Based on Pricing Grid, Attachment B
8	Average Short Term Borrowing Rate	2.480	Ln 6 + 7
9	Average Short Term Borrowing Rate - Rounded	2.500	Agrees to PRM-1, Page 1 of 2

Annex A

PRICING GRID

The "Applicable Rate" for any day with respect to any Eurodollar Loan, ABR Loan, Facility Fee or LC Risk Participation Fee, as the case may be, is the percentage set forth below in the applicable row under the column corresponding to the Status that exists on such day:

Status	Level I	Level II	Level III	Level IV	Level V
Eurodollar Revolving Loans (basis points)	100	107.5	127.5	147.5	165
ABR Loans (basis points)	0	7.5	27.5	47.5	65
Facility Fee (basis points)	12.5	17.5	22.5	27.5	35
LC Risk Participation Fee (basis points)	100	107.5	127.5	147.5	165

For purposes of this Pricing Grid, the following terms have the following meanings (as modified by the provisos below):

"***Level I Status***" exists at any date if, at such date, the Index Debt is rated either A- or higher by S&P or A3 or higher by Moody's.

"***Level II Status***" exists at any date if, at such date, the Index Debt is rated either BBB+ by S&P or Baa1 by Moody's.

"***Level III Status***" exists at any date if, at such date, the Index Debt is rated either BBB by S&P or Baa2 by Moody's.

"***Level IV Status***" exists at any date if, at such date, the Index Debt is rated either BBB- by S&P or Baa3 by Moody's.

"***Level V Status***" exists at any date if, at such date, the Index Debt is rated either BB+ by S&P or lower or Ba1 by Moody's or lower, or, no other Status exists.

"***Status***" refers to the determination of which of Level I Status, Level II Status, Level III Status, Level IV Status or Level V Status exists at any date.

The credit ratings to be utilized for purposes of this Pricing Grid are those assigned to the Index Debt, and any rating assigned to any other debt security of the Borrower shall be disregarded. The rating in effect at any date is that in effect at the close of business on such date.

Provided, that the applicable Status shall change as and when the applicable Index Debt ratings change.

Provided further, that if the Index Debt is split-rated, the applicable Status shall be determined on the basis of the higher of the two ratings then applicable; *provided further, that,* if the Index Debt is split-rated by two or more levels, the applicable Status shall instead be determined on the basis of the rating that is one level above the lower of the two ratings then applicable.

Provided further, that if both Moody's and S&P, or their successors as applicable, shall have ceased to issue or maintain such ratings, then the applicable Status shall be Level V.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

30. Provide Columbia's component capital structure for the years 2010 through 2015. Please show each source of capital separately. Include all work papers and supporting documentation. Provide all spreadsheets with cell formulas intact.

Response:

Please refer to AG 1-30 Attachment A, filed in this docket as CKY_R_AGDR1_NUM30_Attachment_A_072216.

Columbia Gas of Kentucky, Inc.

Case No. 2016-00162

Comparative Capital Structures (Excluding JDIC)
For the Periods as Shown

Line No.	Columbia Gas of Kentucky, Inc.	December 31 2010		December 31 2011		December 31 2012		December 31 2013		December 31 2014		December 31, 2015	
	Type of Capital	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio
1.	Long-Term Debt [1]	$ 82,055,000	47.86%	$82,055,000	47.60%	$ 82,055,000	47.18%	$ 93,335,000	48.18%	$ 98,335,000	47.09%	$ 98,335,000	46.22%
2.	Short-Term Debt	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
3.	Preferred & Preference Stock												
4.	Common Equity	$ 89,397,098	52.14%	$90,341,540	52.40%	$ 91,857,265	52.82%	$ 100,385,865	51.82%	$ 110,500,615	52.91%	$ 114,423,317	53.78%
5.	Other (Itemize by type)												
6.	Total Capitalization	$ 171,452,098	100.00%	$172,396,540	100.00%	$173,912,265	100.00%	$193,720,865	100.00%	$208,835,615	100.00%	$ 212,758,317	100.00%

[1] Long-Term Debt balances include the current portion of Long-Term Debt.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

31. Provide copies of credit rating agency reports, e.g., Standard and Poor's, Moody's, and Fitch, for the Gas Group (See Moul Direct Testimony, page 15, lines 11 through 16) from 2013 through the present date.

Response:

Mr. Moul does not possess credit rating agency reports from Standard & Poor's, Moody's, and Fitch for the members of the Gas Group. The source that was used by Mr. Moul for lines 11 through 16 of page 15 of his direct testimony is attached.

Atmos Energy Corporation (NYSE: ATO)
Ratings Details

Credit Ratings

	Moody's	S&P	Fitch Ratings
Long-term Rating	A2	A-	A-
Outlook	Stable	Stable	Stable
Watch	-	-	-
As of Date	1/30/2014	10/8/2013	7/1/2015
	Baa1 (WP)	BBB+ (OS)	BBB+ (OP)
	Affirm	Upgrade	Affirm
	11/8/2013	12/23/2008	10/1/2014
	Baa1 (OS)	BBB (OP)	BBB+ (OP)
	Upgrade	Affirm	Affirm
	5/11/2011	6/11/2007	5/21/2014
	Baa2 (WP)	BBB (OS)	BBB+ (OS)
	Affirm	Affirm	Affirm
	3/31/2011	12/22/2005	4/29/2013
	Baa2 (OP)	BBB	BBB+ (OS)
	Affirm	Downgrade	Affirm
	3/19/2010	9/30/2004	4/30/2012
	Baa2	A- (WN)	BBB+ (OS)
	Upgrade	Affirm	Upgrade
	5/18/2009	6/17/2004	6/2/2011

Comparison with Peers: Moody's - SNL Default Peer Group

Company Name	Long-term Rating	Outlook	Watch	As of Date
Atmos Energy Corp.	A2	Stable	-	1/30/2014
WGL Holdings Inc.	A3	Stable	-	10/22/2014
Questar Corp.	A2	Stable	-	9/2/2014
Laclede Group Inc.	Baa2	Stable	-	8/12/2014
National Fuel Gas Co.	Baa2	Stable	-	4/23/2014
Northwest Natural Gas Co.	(P)A3	Stable	-	2/18/2014
Southwest Gas Corp.	A3	Stable	-	1/31/2014
Piedmont Natural Gas Co. Inc.	A2	Stable	-	1/31/2014
ONE Gas Inc.	A2	Stable	-	1/13/2014

Credit Ratings Details

	Moody's	S&P	Fitch Ratings
Long-term Issuer	-	A- (OS)	A- (OS)
		Upgrade	Upgrade
		10/8/2013	7/1/2015
	-	BBB+ (OS)	BBB+ (OP)
		Upgrade	Affirm
		12/23/2008	10/1/2014
	-	BBB (OP)	BBB+ (OP)
		Affirm	Affirm
		6/11/2007	5/21/2014
	-	BBB (OS)	BBB+ (OS)
		Affirm	Affirm
		12/22/2005	4/29/2013
	-	BBB	BBB+ (OS)
		Downgrade	Affirm
		9/30/2004	4/30/2012
	-	A- (WN)	BBB+ (OS)
		Affirm	Upgrade
		6/17/2004	6/2/2011
Senior Unsecured	A2 (OS)	A-	A
	Upgrade	Upgrade	Upgrade
	1/30/2014	10/8/2013	7/1/2015
	Baa1 (WP)	BBB+	A-
	Affirm	Upgrade	Affirm
	11/8/2013	12/23/2008	10/1/2014
	Baa1 (OS)	BBB	A-
	Upgrade	Affirm	Affirm
	5/11/2011	6/11/2007	5/21/2014
	Baa2 (WP)	BBB	A-
	Affirm	Affirm	Affirm
	3/31/2011	12/22/2005	4/29/2013

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Atmos Energy Corporation (NYSE: ATO)
Ratings Details

	Baa2 (OP) Affirm 3/19/2010	BBB (WR) Downgrade 9/30/2004	A- Affirm 4/30/2012
	Baa2 (OS) Upgrade 5/18/2009	A- SNL Start	A- Upgrade 6/2/2011
Short-term/Commercial Paper	P-1 Affirm 12/5/2014	A-2 Affirm 6/11/2007	F2 Affirm 7/1/2015
	P-1 Upgrade 1/30/2014	A-2 (WR) Affirm 9/30/2004	F2 Affirm 10/1/2014
	P-2 (WR) Affirm 5/11/2011	A-2 (WN) Affirm 6/17/2004	F2 Affirm 5/21/2014
	P-2 (WP) Affirm 3/31/2011	A-2 Affirm 1/10/2003	F2 Affirm 4/29/2013
	P-2 Upgrade 5/18/2009	A-2 Affirm 10/16/1998	F2 Affirm 4/30/2012
	P-3 (WP) Affirm 3/23/2009	A-2 SNL Start	F2 Affirm 6/2/2011
Senior Secured Debt	-	- Remove 8/20/2008	- Remove 1/13/2006
	-	A- Affirm 6/11/2007	BBB+ (WR) Downgrade 9/30/2004
	-	A- Upgrade 12/22/2005	A- (WN) Affirm 6/17/2004
	-	BBB (WR) Downgrade 9/30/2004	A- Affirm 2/27/2004
	-	A- (WN) Affirm 6/17/2004	A- SNL Start
	-	A- Affirm 1/10/2003	-

Ratings News

Action Items: Moody's upgrades 6 gas companies; GenOn Energy placed on review for downgrade 2/6/2014 10:41 AM ET
SNL Energy presents a periodic rundown of selected ratings actions on U.S.-based energy companies.

Moody's upgrades, assigns stable outlooks to 6 gas companies 1/31/2014 12:41 PM ET
Moody's on Jan. 30 upgraded the ratings of Washington Gas Light, Atmos Energy, SourceGas, SEMCO Energy, PNG and New Jersey Natural Gas. All entities were assigned a rating outlook of stable.

Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET
Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

Includes credit ratings on or after January 1, 2000. If a listed rating does not have a date, this means that while the rating was available from the ratings agency, the date was not available as of our data collection starting point. SNL does not publish revised Rating Outlooks independent of the credit rating itself. If there is a revised outlook where the credit rating stayed the same SNL lists this as a rating affirmation. Ratings history is comprehensive beginning with SNL's coverage of a company.

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Atmos Energy Corporation (NYSE: ATO)
Ratings Details

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Atmos Energy Corporation (NYSE: ATO)
Subsidiaries

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Chesapeake Utilities Corporation (NYSE: CPK)
Ratings Details

This information is not currently available for Chesapeake Utilities Corporation

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Chesapeake Utilities Corporation (NYSE: CPK)
Subsidiaries

Subsidiary Credit Ratings Details	Moody's	S&P
Florida Public Utilities Co.		
Long-term Rating	- Remove 7/17/2009	-
	Baa1 (WU) Affirm 4/13/2009	-
	Baa1 (WN) Affirm 3/3/2009	-
	Baa1 (OS) Downgrade 11/5/2008	-
	Aa3 (OS) Downgrade 6/19/2008	-
	Aaa (WN) Affirm 1/16/2008	-
Senior Secured Debt	- Remove 7/17/2009	- Remove 7/28/2009
	Baa1 (WU) Affirm 4/13/2009	BBB (WN) Downgrade 6/24/2009
	Baa1 (WN) Affirm 3/3/2009	AA (WN) SNL Start 6/5/2008
	Baa1 (OS) Downgrade 11/5/2008	-
	Aa3 (OS) Downgrade 6/19/2008	-
	Aaa (WN) Affirm 1/16/2008	-

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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Laclede Group, Inc. (The) (NYSE: LG)
Ratings Details

Credit Ratings

	Moody's	S&P	Fitch Ratings
Long-term Rating	Baa2	A-	BBB+
Outlook	Stable	Stable	Stable
Watch	-	-	-
As of Date	8/12/2014	6/13/2014	10/1/2014
	(P)Baa2 (OS)	A- (WN)	BBB+ (OS)
	Downgrade	Affirm	Affirm
	7/22/2014	4/7/2014	8/8/2014
	(P)Baa1 (ON)	A- (OS)	BBB+ (WN)
	Affirm	Downgrade	Affirm
	4/7/2014	7/19/2013	4/7/2014
	(P)Baa1 (OS)	A (WN)	BBB+ (OS)
	Upgrade	Affirm	Downgrade
	1/31/2014	4/4/2013	8/2/2013
	(P)Baa2 (WP)	A (ON)	A- (WN)
	Affirm	Affirm	Affirm
	11/8/2013	12/17/2012	12/17/2012
	(P)Baa2 (OS)	A (OS)	A- (OS)
	Affirm	Affirm	Affirm
	7/26/2013	3/26/2008	12/12/2012

Comparison with Peers: Moody's - SNL Default Peer Group

Company Name	Long-term Rating	Outlook	Watch	As of Date
Laclede Group Inc.	Baa2	Stable	-	8/12/2014
WGL Holdings Inc.	A3	Stable	-	10/22/2014
Questar Corp.	A2	Stable	-	9/2/2014
National Fuel Gas Co.	Baa2	Stable	-	4/23/2014
Northwest Natural Gas Co.	(P)A3	Stable	-	2/18/2014
Southwest Gas Corp.	A3	Stable	-	1/31/2014
Piedmont Natural Gas Co. Inc.	A2	Stable	-	1/31/2014

Credit Ratings Details

	Moody's	S&P	Fitch Ratings
Long-term Issuer	-	A- (OS)	BBB+ (OS)
		Affirm	Affirm
		6/13/2014	10/1/2014
	-	A- (WN)	BBB+ (OS)
		Affirm	Affirm
		4/7/2014	8/8/2014
	-	A- (OS)	BBB+ (WN)
		Downgrade	Affirm
		7/19/2013	4/7/2014
	-	A (WN)	BBB+ (OS)
		Affirm	Downgrade
		4/4/2013	8/2/2013
	-	A (ON)	A- (WN)
		Affirm	Affirm
		12/17/2012	12/17/2012
	-	A (OS)	A- (OS)
		Affirm	Affirm
		3/26/2008	12/12/2012

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Laclede Group, Inc. (The) (NYSE: LG)
Ratings Details

Senior Unsecured	Baa2 (OS) Affirm 8/12/2014	BBB+ Initiate 8/13/2014	BBB+ Affirm 10/1/2014
	(P)Baa2 (OS) Downgrade 7/22/2014	-	BBB+ Initiate 8/12/2014
	(P)Baa1 (ON) Affirm 4/7/2014	-	-
	(P)Baa1 (OS) Upgrade 1/31/2014	-	-
	(P)Baa2 (WP) Affirm 11/8/2013	-	-
	(P)Baa2 (OS) Affirm 7/26/2013	-	-
Trust Preferred	-	-	- Remove 6/6/2008
	-	-	BBB+ Affirm 6/20/2007
	-	-	BBB+ Affirm 6/6/2006
	-	-	BBB+ SNL Start 12/9/2002

Ratings News

Action items: Moody's lowers GenOn Energy ratings; Edison International wins S&P upgı 4/21/2014 9:22 AM ET
SNL Energy presents a periodic rundown of selected rating actions on U.S.- and Canada-based energy companies.

Fitch puts Laclede Group on Rating Watch Negative on Alagasco deal announcement 4/8/2014 12:56 PM ET
Fitch Ratings said April 7 that it placed the issuer default rating of Laclede Group Inc. on Rating Watch Negative following the company's recent announcement to acquire Alabama Gas Corp. for $1.6 billion.

Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET
Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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Laclede Group, Inc. (The) (NYSE: LG)
Subsidiaries

Subsidiary Credit Ratings Details	Moody's	S&P	Fitch Ratings
Alabama Gas Corp.			
Long-term Rating	A2 (OS)	A- (OS)	-
	Affirm	Upgrade	
	9/2/2014	9/2/2014	
	A2 (WU)	BBB- (WP)	-
	Affirm	Affirm	
	4/8/2014	4/9/2014	
	A2 (ON)	BBB- (ON)	-
	Downgrade	Downgrade	
	4/25/2013	12/16/2013	
	A1 (WN)	BBB (WN)	-
	Affirm	Affirm	
	1/28/2013	11/26/2013	
	A1 (OS)	BBB (OS)	-
	Affirm	Downgrade	
	9/24/2007	2/25/2009	
	A1 (WN)	BBB+ (WN)	-
	Affirm	Affirm	
	8/24/2007	10/15/2008	
Senior Unsecured	A2 (OS)	A- (WR)	-
	Affirm	Upgrade	
	9/2/2014	9/2/2014	
	A2 (WU)	BBB- (WP)	-
	Affirm	Affirm	
	4/8/2014	4/9/2014	
	A2 (ON)	BBB-	-
	Downgrade	Downgrade	
	4/25/2013	12/16/2013	
	A1 (WN)	BBB (WN)	-
	Affirm	Affirm	
	1/28/2013	11/26/2013	
	A1 (OS)	BBB (WR)	-
	Affirm	Downgrade	
	9/24/2007	2/25/2009	
	A1 (WN)	BBB+ (WN)	-
	Affirm	Affirm	
	8/24/2007	10/15/2008	
Laclede Gas Co.			
Long-term Rating	(P)A3 (OS)	A- (OS)	BBB+ (OS)
	Affirm	Affirm	Affirm
	7/22/2014	6/13/2014	10/1/2014
	(P)A3 (OS)	A- (WN)	BBB+ (OS)
	Upgrade	Affirm	Affirm
	1/31/2014	4/7/2014	8/8/2014
	(P)Baa1 (WP)	A- (OS)	BBB+ (OS)
	Affirm	Downgrade	Affirm
	11/8/2013	7/19/2013	4/7/2014
	(P)Baa1 (OS)	A (WN)	BBB+ (OS)
	Affirm	Affirm	Downgrade
	7/26/2013	4/4/2013	8/2/2013
	(P)Baa1 (ON)	A (ON)	A- (OS)
	Affirm	Affirm	Affirm
	12/17/2012	12/17/2012	12/17/2012
	(P)Baa1 (OS)	A (OS)	A- (OS)
	Affirm	Downgrade	Affirm
	11/15/2003	5/5/2003	12/12/2012

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Laclede Group, Inc. (The) (NYSE: LG)
Subsidiaries

Senior Unsecured	(P)A3 (OS) Affirm 7/22/2014	-	-
	(P)A3 (OS) Upgrade 1/31/2014	-	-
	(P)Baa1 (WP) Affirm 11/8/2013	-	-
	(P)Baa1 (OS) Affirm 7/26/2013	-	-
	(P)Baa1 (ON) Affirm 12/17/2012	-	-
	(P)Baa1 (OS) Affirm 11/15/2003	-	-
Short-term/Commercial Paper	P-2 Affirm 7/22/2014	A-2 (WR) Downgrade 7/19/2013	F2 Affirm 10/1/2014
	P-2 Affirm 1/31/2014	A-1 (WN) Affirm 4/4/2013	F2 Affirm 8/8/2014
	P-2 Affirm 7/26/2013	A-1 Downgrade 4/24/2002	F2 Affirm 4/7/2014
	P-2 Downgrade 8/6/2002	A-1+ (WN) SNL Start	F2 Downgrade 8/2/2013
	P-1 Affirm 5/2/2002	-	F1 Affirm 12/17/2012
	P-1 SNL Start	-	F1 Affirm 12/12/2012
Senior Secured Debt	A1 Affirm 7/22/2014	A (WR) Downgrade 7/19/2013	A Affirm 10/1/2014
	A1 Upgrade 1/31/2014	A+ (WN) Affirm 4/4/2013	A Affirm 8/8/2014
	A2 (WP) Affirm 11/8/2013	A+ Upgrade 2/14/2013	A Affirm 4/7/2014
	A2 Affirm 7/26/2013	A Downgrade 5/5/2003	A Downgrade 8/2/2013
	A2 Upgrade 8/3/2009	A+ Downgrade 4/24/2002	A+ Affirm 12/17/2012
	A3 Downgrade 8/6/2002	AA- SNL Start	A+ Affirm 12/12/2012

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Laclede Group, Inc. (The) (NYSE: LG)
Subsidiaries

Ratings News

Action items: Moody's lowers GenOn Energy ratings; Edison International wins S&P upgı 4/21/2014 9:22 AM ET
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Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET
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Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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New Jersey Resources Corporation (NYSE: NJR)
Ratings Details

This information is not currently available for New Jersey Resources Corporation

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New Jersey Resources Corporation (NYSE: NJR)
Subsidiaries

Subsidiary Credit Ratings Details		
	Moody's	**S&P**
New Jersey Natural Gas Co.		
Long-term Rating	(P)Aa2 (OS)	A (OS)
	Upgrade	Affirm
	1/30/2014	4/30/2009
	(P)Aa3 (WP)	A (ON)
	Affirm	Downgrade
	11/8/2013	4/3/2008
	(P)Aa3 (OS)	A+ (ON)
	Affirm	Affirm
	8/27/2010	6/19/2006
	Aa3 (OS)	A+
	Affirm	Upgrade
	12/22/2009	9/3/2003
	Aa3 (ON)	A
	Affirm	SNL Start
	12/17/2008	
	Aa3 (OS)	-
	Affirm	
	11/15/2003	
Short-term/Commercial Paper	P-1	A-1
	Affirm	Affirm
	11/15/2003	4/3/2008
	P-1	A-1
	Affirm	Affirm
	9/4/2003	6/19/2006
	P-1	A-1
	Affirm	Affirm
	6/25/2003	9/3/2003
	P-1	A-1
	Upgrade	Affirm
	11/8/1983	3/29/1979
	P-2	A-1
	SNL Start	SNL Start
Senior Secured Debt	(P)Aa2 (OS)	-
	Upgrade	Remove
	1/30/2014	11/1/2008
	(P)Aa3 (WP)	A+
	Affirm	Downgrade
	11/8/2013	4/3/2008
	(P)Aa3 (OS)	AA-
	Affirm	Affirm
	8/27/2010	6/19/2006
	Aa3 (OS)	AA-
	Affirm	Upgrade
	12/22/2009	9/3/2003
	Aa3 (ON)	A+
	Affirm	Upgrade
	12/17/2008	10/14/1997
	Aa3 (OS)	A
	Affirm	SNL Start
	11/15/2003	

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New Jersey Resources Corporation (NYSE: NJR) Subsidiaries

Ratings News

Action Items: Moody's upgrades 6 gas companies; GenOn Energy placed on review for c 2/6/2014 10:41 AM ET
SNL Energy presents a periodic rundown of selected ratings actions on U.S.-based energy companies.

Moody's upgrades, assigns stable outlooks to 6 gas companies 1/31/2014 12:41 PM ET
Moody's on Jan. 30 upgraded the ratings of Washington Gas Light, Atmos Energy, SourceGas, SEMCO Energy, PNG and New Jersey Natural Gas. All entities were assigned a rating outlook of stable.

Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET
Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

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Northwest Natural Gas Company (NYSE: NWN)
Ratings Details

Credit Ratings

	Moody's	S&P	Fitch Ratings
Long-term Rating	(P)A3	A+	-
Outlook	Stable	Stable	-
Watch	-	-	-
As of Date	2/18/2014	1/25/2010	1/5/2007
	(P)A3 (ON)	AA- (ON)	A (OS)
	Affirm	Affirm	Affirm
	12/19/2012	12/19/2008	12/6/2005
	(P)A3 (OS)	AA- (OS)	A (OS)
	Affirm	Affirm	Upgrade
	12/15/2008	3/7/2006	6/7/2005
	(P)A3 (OP)	AA- (OS)	A-
	Affirm	Upgrade	Affirm
	7/13/2007	2/28/2006	9/29/2004
	(P)A3	A+ (OS)	A-
	SNL Start	Upgrade	Affirm
	4/21/2004	1/4/2005	9/26/2003
	-	A (WR)	A- (WR)
		Affirm	Affirm
		7/25/2002	9/6/2002

Comparison with Peers: Moody's - SNL Default Peer Group

Company Name	Long-term Rating	Outlook	Watch	As of Date
Northwest Natural Gas Co.	(P)A3	Stable	-	2/18/2014
National Fuel Gas Co.	Baa2	Stable	-	4/23/2014

Credit Ratings Details

	Moody's	S&P	Fitch Ratings
Long-term Issuer	-	A+ (OS)	-
		Downgrade	Remove
		1/25/2010	1/5/2007
	-	AA- (ON)	A (OS)
		Affirm	Affirm
		12/19/2008	12/6/2005
	-	AA- (OS)	A (OS)
		Affirm	Upgrade
		3/7/2006	6/7/2005
	-	AA- (OS)	A-
		Upgrade	Affirm
		2/28/2006	9/29/2004
	-	A+ (OS)	A-
		Upgrade	Affirm
		1/4/2005	9/26/2003
	-	A (WR)	A- (WR)
		Affirm	Affirm
		7/25/2002	9/6/2002

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Northwest Natural Gas Company (NYSE: NWN)
Ratings Details

Senior Unsecured	(P)A3 (OS) Affirm 2/18/2014	-	- Remove 1/5/2007
	(P)A3 (ON) Affirm 12/19/2012	-	A Upgrade 6/7/2005
	(P)A3 (OS) Affirm 12/15/2008	-	A- Affirm 9/29/2004
	(P)A3 (OP) Affirm 7/13/2007	-	A- SNL Start
	(P)A3 Initiate 4/21/2004	-	-
Short-term/Commercial Paper	P-2 Affirm 2/18/2014	A-1 Downgrade 1/25/2010	- Remove 1/5/2007
	P-2 Downgrade 12/19/2012	A-1+ Affirm 3/7/2006	F1 Affirm 12/6/2005
	P-1 Affirm 7/13/2007	A-1+ Upgrade 2/28/2006	F1 Affirm 6/7/2005
	P-1 (WR) Affirm 5/17/2002	A-1 Affirm 1/4/2005	F1 Affirm 9/29/2004
	P-1 (WN) Affirm 10/8/2001	A-1 (WR) Affirm 7/25/2002	F1 Affirm 9/26/2003
	P-1 Affirm 5/11/1995	A-1 (WN) Affirm 10/8/2001	F1 (WR) Affirm 9/6/2002
Preferred Stock	- Remove 7/16/2007	-	- Remove 9/29/2004
	Baa2 (WR) Affirm 5/17/2002	-	A- Affirm 9/26/2003
	Baa2 (WN) Affirm 10/8/2001	-	A- (WR) Affirm 9/6/2002
	Baa2 SNL Start	-	A- (WN) Affirm 10/8/2001
	-	-	A- SNL Start

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Northwest Natural Gas Company (NYSE: NWN)
Ratings Details

Senior Secured Debt	A1 Affirm 2/18/2014	AA- Upgrade 2/14/2013	- Remove 1/5/2007
	A1 Upgrade 8/3/2009	A+ Downgrade 6/16/2010	A+ Upgrade 6/7/2005
	A2 Affirm 7/13/2007	AA- Upgrade 3/7/2006	A Affirm 9/29/2004
	A2 (WR) Affirm 5/17/2002	A+ Upgrade 1/4/2005	A Affirm 9/26/2003
	A2 (WN) SNL Start	A SNL Start 5/16/1991	A SNL Start

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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Northwest Natural Gas Company (NYSE: NWN)
Subsidiaries

This information is not currently available for Northwest Natural Gas Company

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South Jersey Industries, Inc. (NYSE: SJI)
Ratings Details

Credit Ratings

	S&P
Long-term Rating	BBB+
Outlook	Stable
Watch	-
As of Date	6/17/2011

Comparison with Peers: Moody's - SNL Default Peer Group

No Peer data available for selected criteria

Credit Ratings Details

	S&P
Long-term Issuer	BBB+ (OS) SNL Start 6/17/2011

Ratings News

Action Items: South Jersey Gas wins Moody's upgrade; Fitch revises Exelon outl 2/19/2014 9:48 AM ET
SNL Energy presents a periodic rundown of selected ratings actions on U.S.-based energy companies.

Moody's upgrades ratings for South Jersey Gas 2/13/2014 1:33 PM ET
Moody's has upgraded the long-term issuer rating of South Jersey Gas Co. to A2 from A3 with a stable outlook.

Moody's puts numerous utility, holding company ratings under review for upgrac 11/11/2013 5:05 PM ET
Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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South Jersey Industries, Inc. (NYSE: SJI)
Subsidiaries

Subsidiary Credit Ratings Details	Moody's	S&P
South Jersey Gas Co.		
Long-term Rating	A2 (OS)	BBB+ (OS)
	Upgrade	Affirm
	1/31/2014	6/19/2006
	A3 (WP)	BBB+ (ON)
	Affirm	Affirm
	11/8/2013	3/29/2005
	A3 (OS)	BBB+
	Upgrade	Affirm
	8/10/2012	7/19/2002
	Baa1 (OS)	BBB+
	Affirm	SNL Start
	3/4/2011	6/3/1993
	Baa1	-
	Initiate	
	8/5/2009	
	-	-
	Remove	
	2/1/2005	
Senior Unsecured	-	-
	Remove	Remove
	11/6/2008	9/11/2006
	Baa2 (OP)	BBB
	Initiate	Affirm
	10/12/2007	6/19/2006
	-	BBB
	Remove	Affirm
	2/1/2005	3/29/2005
	Baa2	BBB
	SNL Start	SNL Start
	1/4/1995	12/21/1994
Short-term/Commercial Paper	P-1	A-2
	Upgrade	SNL Start
	1/31/2014	3/21/2011
	P-2 (WP)	-
	Affirm	
	11/8/2013	
	P-2	-
	SNL Start	
	7/11/2011	

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South Jersey Industries, Inc. (NYSE: SJI)
Subsidiaries

Trust Preferred	- Remove 11/15/2003	- Remove 10/10/2008
	Baa3 SNL Start	BBB- Affirm 6/19/2006
	-	BBB- Affirm 3/29/2005
	-	BBB- Downgrade 2/23/1999
	-	BBB SNL Start
Senior Secured Debt	Aa3 Upgrade 1/31/2014	A Affirm 6/19/2006
	A1 (WP) Affirm 11/8/2013	A Affirm 3/29/2005
	A1 Upgrade 8/10/2012	A Upgrade 10/14/1997
	A2 Upgrade 8/3/2009	BBB+ SNL Start
	A3 (OP) Upgrade 2/4/2009	-
	Baa1 (WP) Affirm 11/6/2008	-

Ratings News

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South Jersey Industries, Inc. (NYSE: SJI)
Subsidiaries

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Southwest Gas Corporation (NYSE: SWX)
Ratings Details

Credit Ratings

	Moody's	S&P	Fitch Ratings
Long-term Rating	A3	BBB+	A-
Outlook	Stable	Stable	Stable
Watch	-	-	-
As of Date	1/31/2014	10/2/2014	7/31/2015
	Baa1 (WP)	A- (WN)	A- (OS)
	Affirm	Affirm	Affirm
	11/8/2013	9/4/2014	10/1/2014
	Baa1 (OS)	A- (OS)	A- (OS)
	Upgrade	Upgrade	Affirm
	3/15/2012	3/19/2013	7/11/2014
	Baa2 (OS)	BBB+ (OS)	A- (OS)
	Upgrade	Upgrade	Affirm
	5/27/2010	4/27/2011	4/7/2014
	Baa3 (OS)	BBB (OP)	A- (OS)
	Downgrade	Affirm	Upgrade
	5/30/2006	4/22/2010	5/28/2013
	Baa2 (WN)	BBB (OS)	BBB+ (OP)
	Affirm	Upgrade	Affirm
	3/10/2006	4/24/2009	5/30/2012

Comparison with Peers: Moody's - SNL Default Peer Group

Company Name	Long-term Rating	Outlook	Watch	As of Date
Southwest Gas Corp.	A3	Stable	-	1/31/2014
WGL Holdings Inc.	A3	Stable	-	10/22/2014
Questar Corp.	A2	Stable	-	9/2/2014
Laclede Group Inc.	Baa2	Stable	-	8/12/2014
National Fuel Gas Co.	Baa2	Stable	-	4/23/2014
Northwest Natural Gas Co.	(P)A3	Stable	-	2/18/2014
Piedmont Natural Gas Co. Inc.	A2	Stable	-	1/31/2014
ONE Gas Inc.	A2	Stable	-	1/13/2014

Credit Ratings Details

	Moody's	S&P	Fitch Ratings
Long-term Issuer	-	BBB+ (OS)	A- (OS)
		Downgrade	Affirm
		10/2/2014	7/31/2015
	-	A- (WN)	A- (OS)
		Affirm	Affirm
		9/4/2014	10/1/2014
	-	A- (OS)	A- (OS)
		Upgrade	Affirm
		3/19/2013	7/11/2014
	-	BBB+ (OS)	A- (OS)
		Upgrade	Affirm
		4/27/2011	4/7/2014
	-	BBB (OP)	A- (OS)
		Affirm	Upgrade
		4/22/2010	5/28/2013
	-	BBB (OS)	BBB+ (OP)
		Upgrade	Affirm
		4/24/2009	5/30/2012

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Southwest Gas Corporation (NYSE: SWX)
Ratings Details

Senior Unsecured	A3 (OS)	BBB+ (WR)	A
	Upgrade	Downgrade	Affirm
	1/31/2014	10/2/2014	7/31/2015
	Baa1 (WP)	A- (WN)	A
	Affirm	Affirm	Affirm
	11/8/2013	9/4/2014	10/1/2014
	Baa1 (OS)	A-	A
	Upgrade	Upgrade	Affirm
	3/15/2012	3/19/2013	7/11/2014
	Baa2 (OS)	BBB+	A
	Upgrade	Upgrade	Affirm
	5/27/2010	4/27/2011	4/7/2014
	Baa3 (OS)	BBB	A
	Downgrade	Upgrade	Upgrade
	5/30/2006	4/24/2009	5/28/2013
	Baa2 (WN)	BBB-	A-
	Affirm	Affirm	Upgrade
	3/10/2006	3/13/2007	5/30/2012
Short-term/Commercial Paper	-	-	F2
			Affirm
			7/31/2015
	-	-	F2
			Affirm
			10/1/2014
	-	-	F2
			Affirm
			7/11/2014
	-	-	F2
			Affirm
			4/7/2014
	-	-	F2
			Affirm
			5/28/2013
	-	-	F2
			Affirm
			5/30/2012
Trust Preferred	-	-	-
	Remove	Remove	Remove
	5/26/2010	4/7/2010	3/1/2010
	Ba1 (OS)	BB+	BB+
	Downgrade	Upgrade	Downgrade
	5/30/2006	4/24/2009	1/22/2010
	Baa3 (WN)	BB	BBB-
	Affirm	Affirm	Affirm
	3/10/2006	3/13/2007	2/1/2008
	Baa3	BB	BBB-
	Affirm	Downgrade	Affirm
	2/27/2004	2/22/1999	1/17/2007
	Baa3	BB+	BBB-
	SNL Start	SNL Start	Affirm
			8/16/2005
	-	-	BBB-
			Affirm
			4/29/2004

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Southwest Gas Corporation (NYSE: SWX)
Ratings Details

Ratings News

Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET

Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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Southwest Gas Corporation (NYSE: SWX)
Subsidiaries

This information is not currently available for Southwest Gas Corporation

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WGL Holdings, Inc. (NYSE: WGL)
Ratings Details

Credit Ratings

	Moody's	S&P	Fitch Ratings
Long-term Rating	A3	A+	A
Outlook	Stable	Stable	Stable
Watch	-	-	-
As of Date	10/22/2014	3/18/2011	4/24/2015
	-	AA- (ON)	A (OS)
		Affirm	Downgrade
		6/9/2010	10/15/2014
	-	AA- (OS)	A+ (OS)
		Affirm	Affirm
		6/27/2007	10/1/2014
	-	AA- (ON)	A+ (OS)
		Affirm	Affirm
		8/2/2006	10/4/2013
	-	AA- (ON)	A+ (OS)
		Affirm	Affirm
		3/2/2005	10/5/2012
	-	AA-	A+ (OS)
		Affirm	Affirm
		7/2/2004	10/7/2011

Comparison with Peers: Moody's - SNL Default Peer Group

Company Name	Long-term Rating	Outlook	Watch	As of Date
WGL Holdings Inc.	A3	Stable	-	10/22/2014
Questar Corp.	A2	Stable	-	9/2/2014
National Fuel Gas Co.	Baa2	Stable	-	4/23/2014
Northwest Natural Gas Co.	(P)A3	Stable	-	2/18/2014
Piedmont Natural Gas Co. Inc.	A2	Stable	-	1/31/2014

Credit Ratings Details

	Moody's	S&P	Fitch Ratings
Long-term Issuer	-	A+ (OS)	A (OS)
		Downgrade	Affirm
		3/18/2011	4/24/2015
	-	AA- (ON)	A (OS)
		Affirm	Downgrade
		6/9/2010	10/15/2014
	-	AA- (OS)	A+ (OS)
		Affirm	Affirm
		6/27/2007	10/1/2014
	-	AA- (ON)	A+ (OS)
		Affirm	Affirm
		8/2/2006	10/4/2013
	-	AA- (ON)	A+ (OS)
		Affirm	Affirm
		3/2/2005	10/5/2012
	-	AA-	A+ (OS)
		Affirm	Affirm
		7/2/2004	10/7/2011

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WGL Holdings, Inc. (NYSE: WGL)
Ratings Details

Senior Unsecured	A3 (OS) Initiate 10/22/2014	A Initiate 10/22/2014	A Affirm 4/24/2015
	-	-	A Downgrade 10/15/2014
	-	-	A+ Affirm 10/1/2014
	-	-	A+ Affirm 10/4/2013
	-	-	A+ Affirm 10/5/2012
	-	-	A+ Affirm 10/7/2011
Short-term/Commercial Paper	P-2 Affirm 10/22/2014	A-1 Downgrade 3/18/2011	F1 Affirm 4/24/2015
	P-2 Affirm 1/30/2014	A-1+ Upgrade 6/16/2010	F1 Affirm 10/15/2014
	P-2 (WP) Affirm 11/8/2013	A-1 Affirm 6/27/2007	F1 Affirm 10/1/2014
	P-2 Upgrade 3/5/2010	A-1 Affirm 8/2/2006	F1 Affirm 10/4/2013
	NP Downgrade 6/29/2004	A-1 Affirm 3/2/2005	F1 Affirm 10/5/2012
	P-3 (WN) Downgrade 6/4/2004	A-1 Downgrade 7/2/2004	F1 Affirm 10/7/2011

Ratings News

Fitch downgrades ratings for WGL Holdings 10/16/2014 9:50 AM ET

Fitch Ratings said Oct. 15 that it downgraded the issuer default rating and senior unsecured debt rating of WGL Holdings Inc. to A from A+ and affirmed its subsidiary Washington Gas Light Co.'s IDR at A+.

Action Items: Moody's upgrades 6 gas companies; GenOn Energy placed on review for d 2/6/2014 10:41 AM ET

SNL Energy presents a periodic rundown of selected ratings actions on U.S.-based energy companies.

Moody's upgrades, assigns stable outlooks to 6 gas companies 1/31/2014 12:41 PM ET

Moody's on Jan. 30 upgraded the ratings of Washington Gas Light, Atmos Energy, SourceGas, SEMCO Energy, PNG and New Jersey Natural Gas. All entities were assigned a rating outlook of stable.

Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET

Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

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WGL Holdings, Inc. (NYSE: WGL)
Ratings Details

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

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WGL Holdings, Inc. (NYSE: WGL)
Subsidiaries

Subsidiary Credit Ratings Details			
	Moody's	**S&P**	**Fitch Ratings**
Washington Gas Light Co.			
Long-term Rating	A1 (OS)	A+ (OS)	A+ (OS)
	Upgrade	Downgrade	Affirm
	1/30/2014	3/18/2011	4/24/2015
	A2 (WP)	AA- (ON)	A+ (OS)
	Affirm	Affirm	Affirm
	11/8/2013	6/9/2010	10/15/2014
	A2 (OS)	AA- (OS)	A+ (OS)
	Affirm	Affirm	Affirm
	6/29/2004	6/27/2007	10/1/2014
	A2 (OS)	AA- (ON)	A+ (OS)
	Affirm	Affirm	Affirm
	11/15/2003	8/2/2006	10/4/2013
	A2	AA- (ON)	A+ (OS)
	Affirm	Affirm	Affirm
	12/13/2002	3/2/2005	10/5/2012
	A2	AA-	A+ (OS)
	SNL Start	Affirm	Affirm
		7/2/2004	10/7/2011
Senior Unsecured	A1 (OS)	A+	AA-
	Upgrade	Downgrade	Affirm
	1/30/2014	3/18/2011	4/24/2015
	A2 (WP)	AA-	AA-
	Affirm	Affirm	Affirm
	11/8/2013	6/27/2007	10/15/2014
	A2 (OS)	AA-	AA-
	Affirm	Affirm	Affirm
	6/29/2004	3/2/2005	10/1/2014
	A2 (OS)	AA-	AA-
	Affirm	Affirm	Affirm
	11/15/2003	7/2/2004	10/4/2013
	A2	AA-	AA-
	Affirm	SNL Start	Affirm
	12/13/2002		10/5/2012
	A2	-	AA-
	SNL Start		Affirm
			10/7/2011
Short-term/Commercial Paper	P-1	A-1	F1
	Affirm	Downgrade	Affirm
	1/30/2014	3/18/2011	4/24/2015
	P-1	A-1+	F1
	Affirm	Upgrade	Affirm
	6/29/2004	6/16/2010	10/15/2014
	P-1	A-1	F1
	Affirm	Affirm	Affirm
	11/15/2003	6/27/2007	10/1/2014
	P-1 (WR)	A-1	F1
	Affirm	Affirm	Affirm
	12/13/2002	8/2/2006	10/4/2013
	P-1 (WN)	A-1	F1
	Affirm	Affirm	Downgrade
	9/5/2002	3/2/2005	10/5/2012
	P-1	A-1	F1+
	Affirm	Downgrade	Affirm
	4/30/2002	7/2/2004	10/7/2011

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WGL Holdings, Inc. (NYSE: WGL)
Subsidiaries

Preferred Stock	A3 Upgrade 1/30/2014	A- Downgrade 3/18/2011	A Affirm 4/24/2015
	Baa1 (WP) Affirm 11/8/2013	A Affirm 6/27/2007	A Affirm 10/15/2014
	Baa1 (WR) Downgrade 12/13/2002	A Affirm 3/2/2005	A Affirm 10/1/2014
	A2 (WN) Downgrade 9/5/2002	A Affirm 7/2/2004	A Affirm 10/4/2013
	A1 (WN) Affirm 4/30/2002	A Affirm 9/23/2002	A Affirm 10/5/2012
	A1 SNL Start	A SNL Start	A Affirm 10/7/2011
Senior Secured Debt	-	A+ SNL Start 3/18/2011	-

Ratings News

Fitch downgrades ratings for WGL Holdings 10/16/2014 9:50 AM ET

Fitch Ratings said Oct. 15 that it downgraded the issuer default rating and senior unsecured debt rating of WGL Holdings Inc. to A from A+ and affirmed its subsidiary Washington Gas Light Co.'s IDR at A+.

Action Items: Moody's upgrades 6 gas companies; GenOn Energy placed on review for d 2/6/2014 10:41 AM ET

SNL Energy presents a periodic rundown of selected ratings actions on U.S.-based energy companies.

Moody's upgrades, assigns stable outlooks to 6 gas companies 1/31/2014 12:41 PM ET

Moody's on Jan. 30 upgraded the ratings of Washington Gas Light, Atmos Energy, SourceGas, SEMCO Energy, PNG and New Jersey Natural Gas. All entities were assigned a rating outlook of stable.

Moody's puts numerous utility, holding company ratings under review for upgrade 11/11/2013 5:05 PM ET

Due to an improved opinion of credit supportiveness of the regulatory environment in the United States, Moody's on Nov. 8 placed ratings of numerous electric and natural gas utility holding companies and their regulated utility subsidiaries under review for upgrade. The action affects approximately $400 billion of debt.

Ratings Watch Action Legend: (WP) Watch Positive, (WN) Watch Negative, (WU) Watch Uncertain, (WR) Watch Removed, (OP) Outlook Positive, (ON) Outlook Negative, (OS) Outlook Stable, (OD) Outlook Developing.

Includes credit ratings on or after January 1, 2000. If a listed rating does not have a date, this means that while the rating was available from the ratings agency, the date was not available as of our data collection starting point. SNL does not publish revised Rating Outlooks independent of the credit rating itself. If there is a revised outlook where the credit rating stayed the same SNL lists this as a rating affirmation. Ratings history is comprehensive beginning with SNL's coverage of a company.

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COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

32. Refer to Mr. Moul's Direct Testimony, page 24, lines 6 through 9. Provide all supporting calculations, documentation, and work papers associated with the 4.95% cost of the new issue of long-term debt. Provide any associated spreadsheets with cell formulas intact.

Response:

The long-term debt rate was calculated by adding the maximum 30 year US Treasury forward rate for 2016 to NiSource's credit spread. Please refer to AG 1-32 Attachment A, filed in this docket as CKY_R_AGDR1_NUM32_Attachment_A_072216, for the calculation.

Average Long Term Borrwing Rate - 30 yr Note

Line No.	Date	Rate	Source
1	3/31/2016	3.016	Forward Treasury Rate per Bloomberg on 8/26/15
2	6/30/2016	3.048	Forward Treasury Rate per Bloomberg on 8/26/15
3	9/30/2016	3.079	Forward Treasury Rate per Bloomberg on 8/26/15
4	12/31/2016	3.108	Forward Treasury Rate per Bloomberg on 8/26/15
5	Max of above	3.108	Maximum rate of lines 1 - 4
6	NiSource Credit Spread	1.850	Per Barclays Debt Pricing Update on 8/17/15
7	Average Long Term Borrowing Rate	4.958	Ln 5 + 6
8	Average Long Term Borrowing Rate - Rounded	4.950	Agrees to Paul Moul Testimony

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

33. Reference the Columbia application generally. Provide the average dollar amount that the Columbia bill is currently for each rate class, and the average dollar amount should the proposed rates go into effect for each rate class.

Response:

Please refer to Attachment MPB-4, Pages 1 – 5 for the average dollar amount that the Columbia bill is currently for each rate class, and the average dollar amount should the proposed rates go into effect for each rate class.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

34. Reference the Columbia application generally. Provide all invoices from outside experts, consultants, and legal counsel related to the current rate case, as well as the total amount expended thus far. Provide this information on an ongoing basis.

Response:

Please see Staff Data Request Set 1-051 and Set 1-055 for the response. This information will be updated on a monthly basis.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

35. Reference the Columbia application generally. Provide full copies of the Board of Directors ("BOD") meeting minutes for every BOD meeting that has taken place from 2014 up until the present time where rates were discussed.

Response:

There are no Columbia BOD meeting minutes from 2014 up until the present time that contain any discussion of rates.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

36. Reference the Columbia application generally. Provide copies of any and all documents, agendas, meeting notices, and/or annual reports relating to or distributed at any and all meetings with customers between 2014 and the present time, which address or otherwise discuss the need for a rate adjustment.

Response:

There are no documents that are responsive to this request.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

37. Reference the Columbia application generally. Has Columbia conducted a study to compare the Company's salary/wages, benefits, and raises per employee with the standard salary/wages, benefits, and raises by the workforce in the counties that it services? If so, provide copies of all such studies. If not, explain why a study has not been performed.

Response:

NiSource operates across multiple states and has the philosophy that we set our benefits and wage structures across all of NiSource based upon data from the energy and general industry. Columbia has participated in and gathered information from surveys to set Columbia's salary/wages, benefits, and raises per employee with the standard salary/wages, benefits, and raises of the broad national workforce. These surveys do not provide detailed data by county. Therefore, Columbia does not have data broken down by county.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

38. Reference the Columbia application generally. Provide copies of any salary surveys/studies or analysis of prevailing wage and salary amounts or any other documents utilized in the process of determining the amount of compensation, benefits, bonuses, and raises for wage and salaried employees.

Response:

Columbia utilizes salary and wage studies provided by third parties. The entities that prepare the studies consider the studies to be highly confidential and Columbia must obtain consent from these entities before providing the studies. The studies are also voluminous. It has not been possible for Columbia to obtain all of the necessary consents, and copy all of the studies, in time to respond to this data request by July 22, 2016. Therefore, in a July 21, 2016, telephone conversation between Stephen Seiple (attorney for Columbia) and Kent Chandler (attorney for the Attorney General's office) Columbia and the Attorney General's office have

agreed that Columbia may have until July 29, 2016, to provide information responsive to this request.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

39. Reference the Columbia application generally to answer the following:

a. Provide a list of each Columbia salaried employee's job title with salary, overtime pay if any, percent pay increase for each of the past five years, and also include all benefits, bonuses, awards, etc.

b. Provide a list of each Columbia hourly employee's job title with salary, overtime pay if any, percent pay increase for each of the past five years, and also include all benefits, bonuses, awards, etc.

c. Provide a list of each Columbia BOD's job title with salary, overtime pay if any, percent pay increase for each of the past five years, and also include all benefits, bonuses, awards, etc.

d. Provide a list of each Columbia Officer's job title with salary, overtime if any, percent pay increase for each of the past five years, and also include all benefits, bonuses, awards, etc.

Response:

a. See AG 1-39 Attachments A-E (Confidential) for a list of each Columbia salaried employee's job level with salary (as of 12/31 of 2012-2015 and as of 6/30/16), overtime pay if any, percent pay increase for each of the past five years, and bonuses/awards. Details about the benefit packages provided to employees is included in Columbia's response to AG-1-44. See the table at the end of this response for a reference to the attachments.

b. See AG 1-39 Attachments F-J (Confidential) for a list of each Columbia hourly employee's job level with salary (as of 12/31 of 2012-2015 and as of 6/30/16), overtime pay if any, percent pay increase for each of the past five years, and bonuses/awards. Details about the benefit packages provided to employees is included in AG-1-44. See the table at the end of this response for a reference to the attachments.

c. Please see Columbia's response to Staff Set 1-037 for responses to both subparts c. and d. Also, please refer to Attachment K of the response.

d. Please see Columbia's response to Staff Set 1-037 for responses to both subparts c. and d. Also, please refer to Attachment L of the response.

Data Request	Attachment Name	Year
AG Set 1 - 39 (a)	AG 1-39 Attachment A (Confidential)	2012
AG Set 1 - 39 (a)	AG 1-39 Attachment B (Confidential)	2013
AG Set 1 - 39 (a)	AG 1-39 Attachment C (Confidential)	2014
AG Set 1 - 39 (a)	AG 1-39 Attachment D (Confidential)	2015
AG Set 1 - 39 (a)	AG 1-39 Attachment E (Confidential)	2016
AG Set 1 - 39 (b)	AG 1-39 Attachment F (Confidential)	2012
AG Set 1 - 39 (b)	AG 1-39 Attachment G (Confidential)	2013
AG Set 1 - 39 (b)	AG 1-39 Attachment H (Confidential)	2014
AG Set 1 - 39 (b)	AG 1-39 Attachment I (Confidential)	2015
AG Set 1 - 39 (b)	AG 1-39 Attachment J (Confidential)	2016

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Director/Manager				
Executive				
Exempt Individual Contributor				
Team Leader/Sr Lvl Individual Contributor				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Director/Manager				
Executive				
Exempt Individual Contributor				
Team Leader/Sr Lvl Individual Contributor				

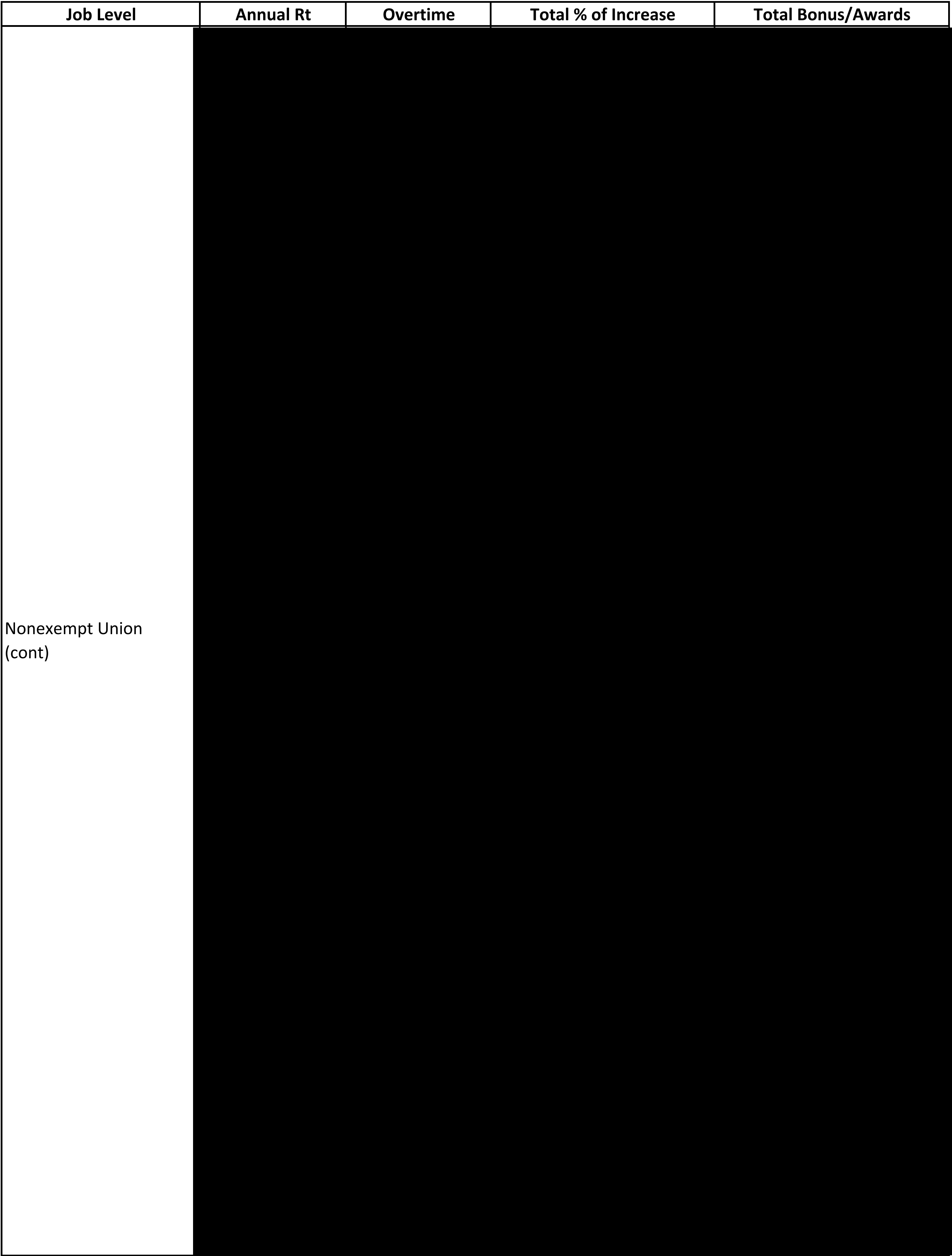
Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Director/Manager				
Executive				
Exempt Individual Contributor				
Team Leader/Sr Lvl Individual Contributor				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Director/Manager				
Executive				
Exempt Individual Contributor				
Team Leader/Sr Lvl Individual Contributor				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Director/Manager				
Executive				
Exempt Individual Contributor				
Team Leader/Sr Lvl Individual Contributor				

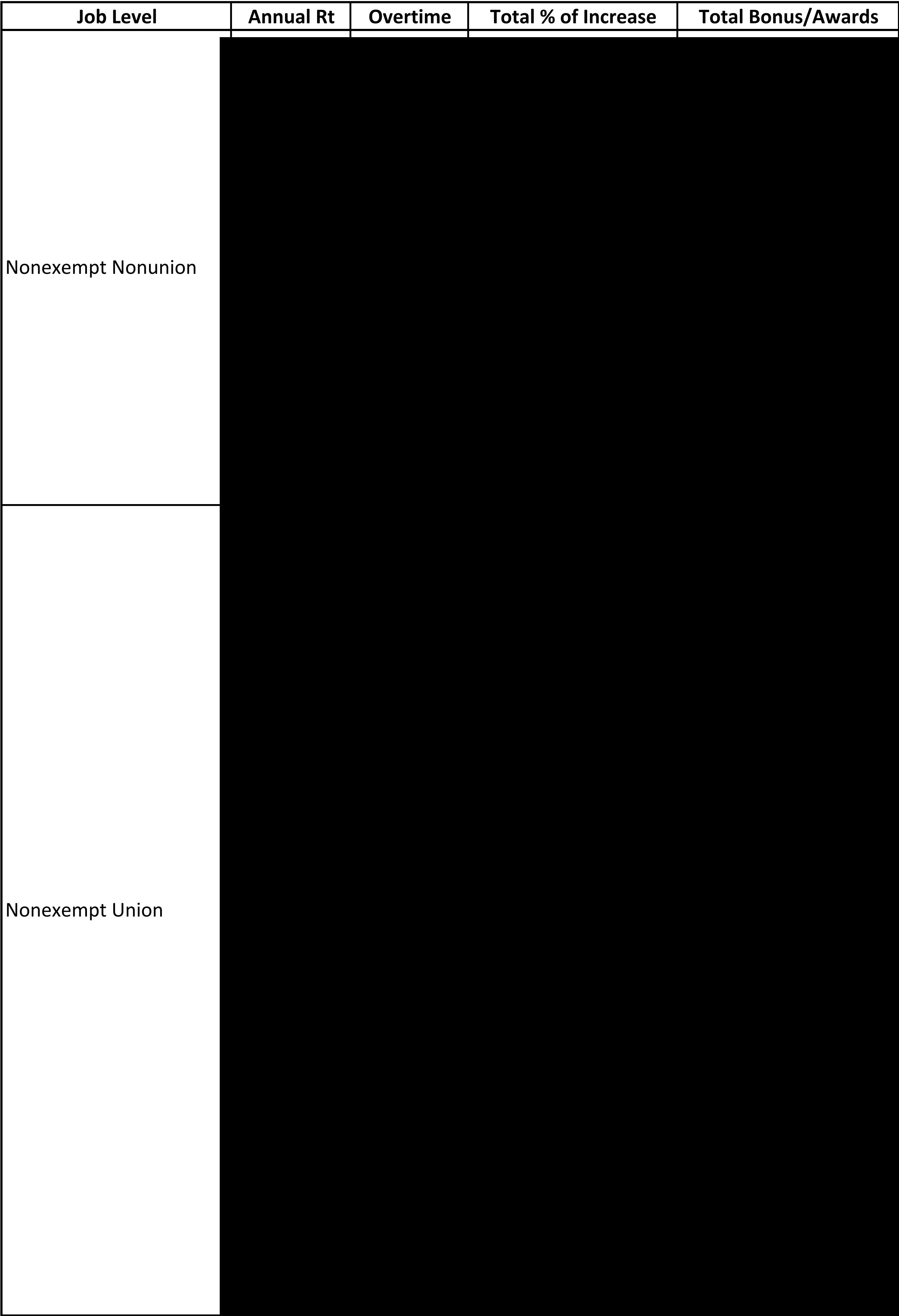
* Data as of June 30, 2016

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Nonunion				
Nonexempt Union				

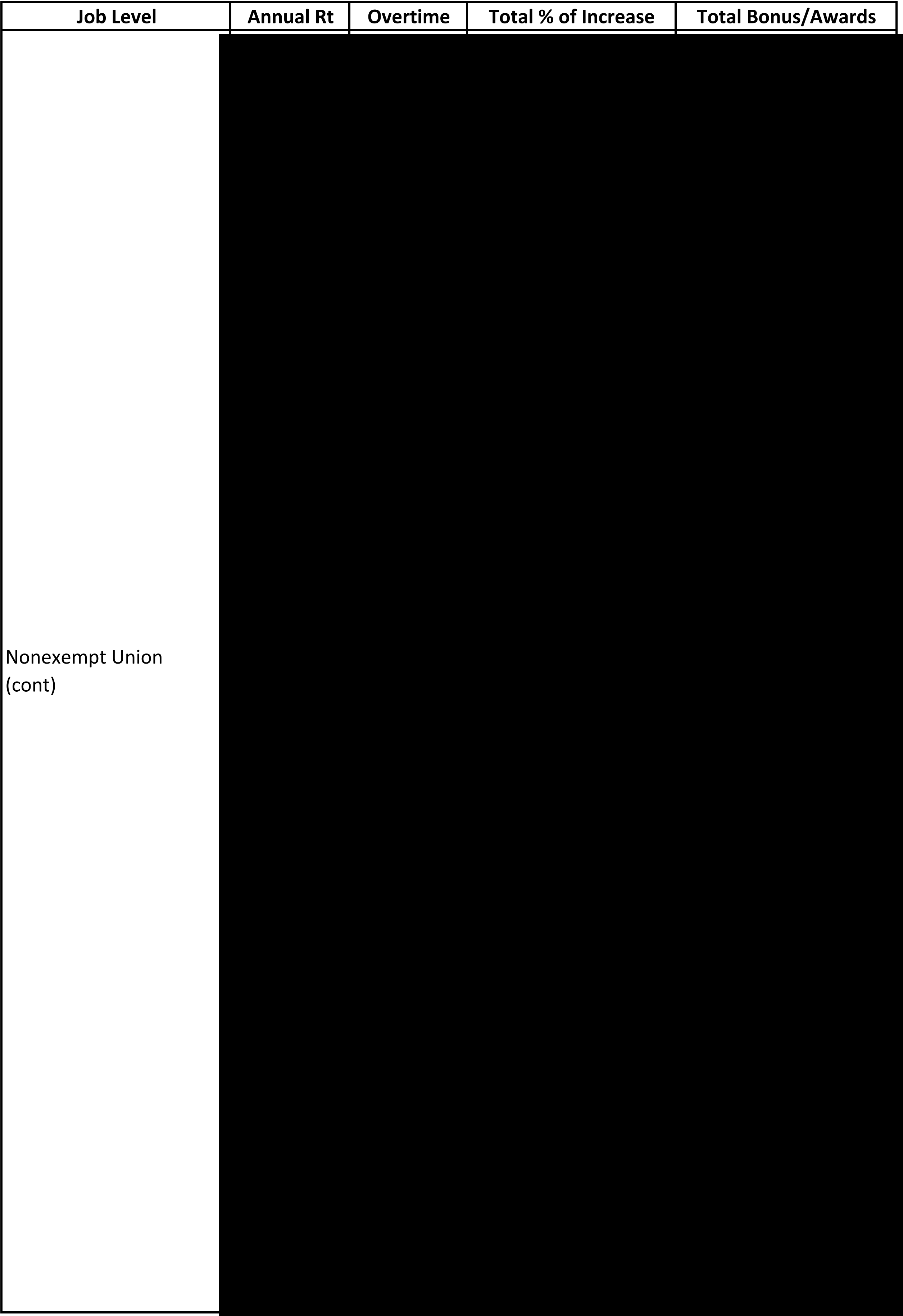


Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

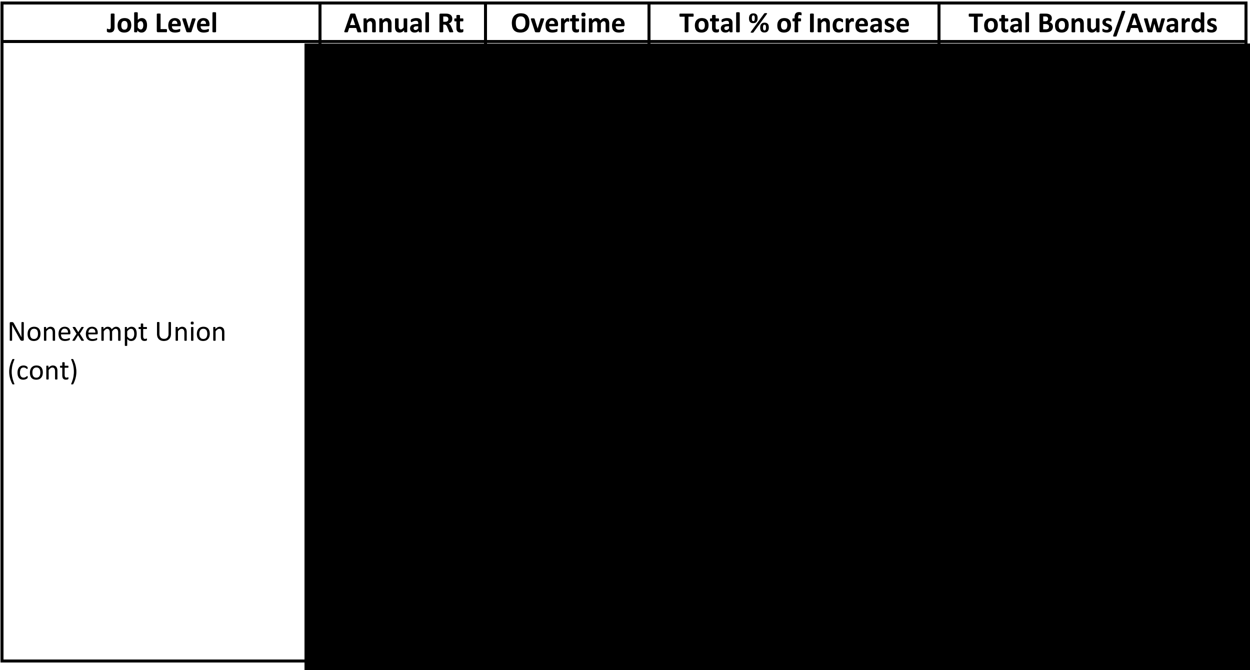
Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

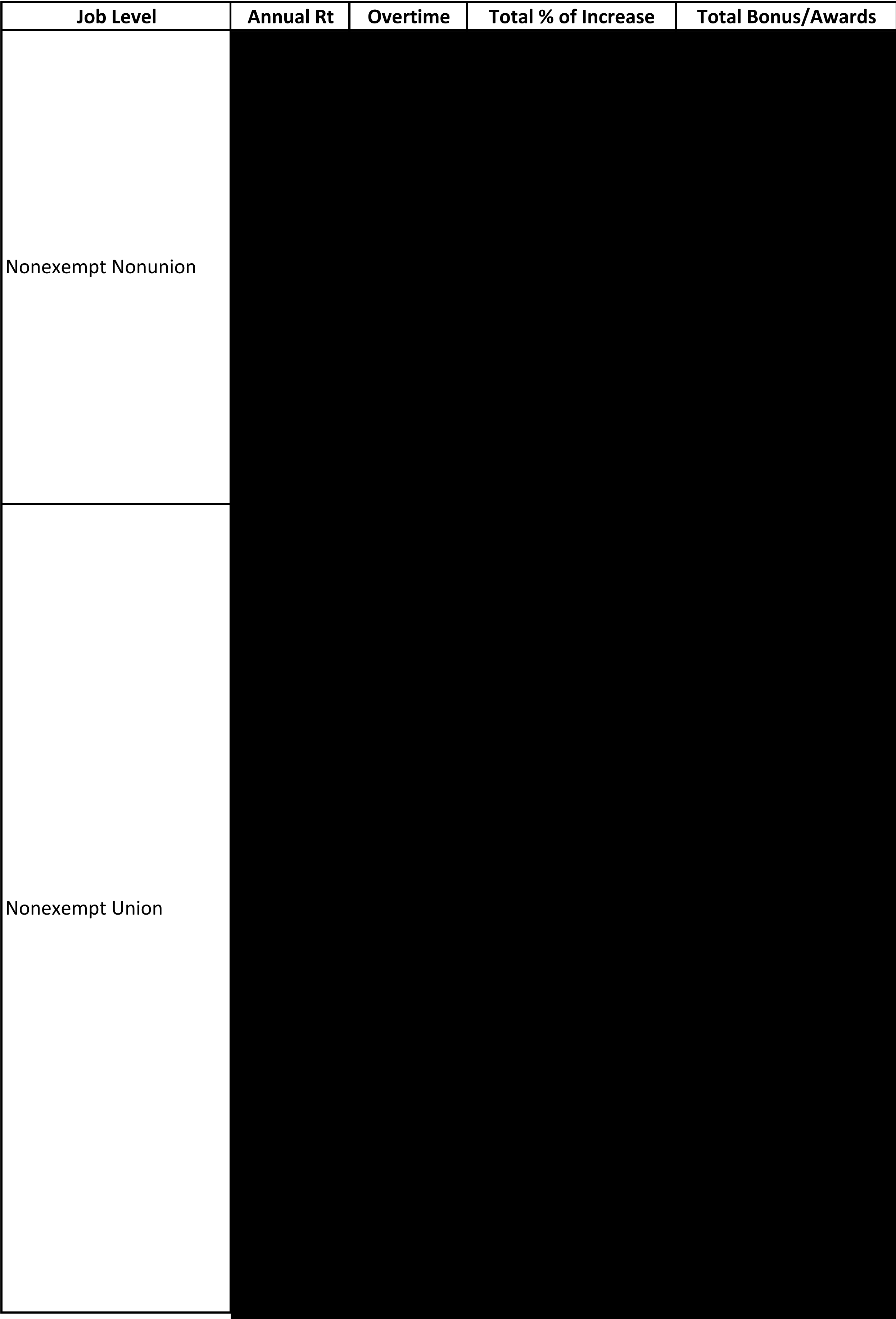


Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Nonunion				
Nonexempt Union				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

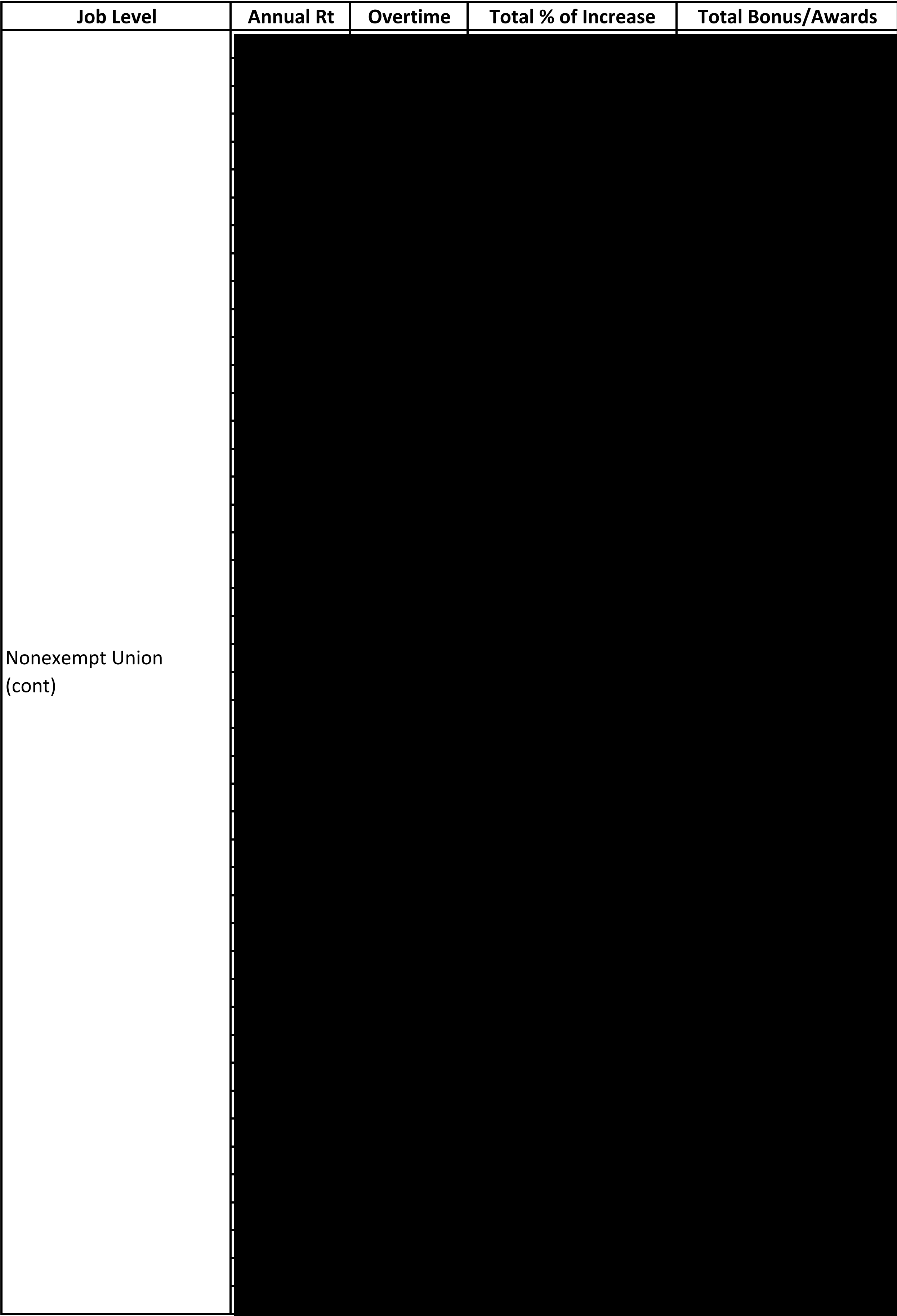
Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

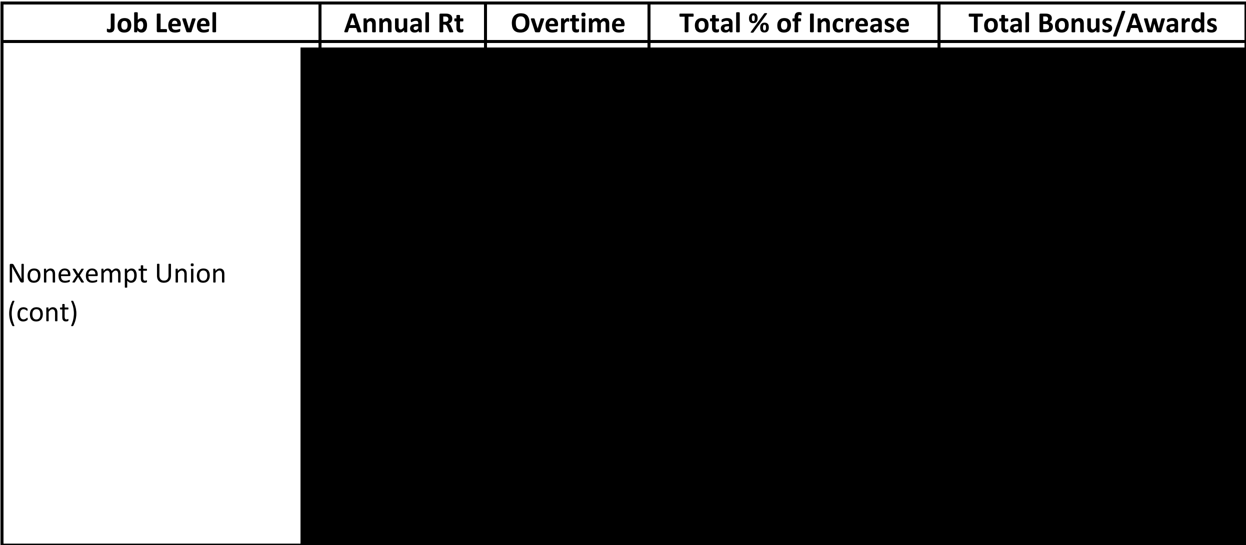




Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Nonunion				
Nonexempt Union				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

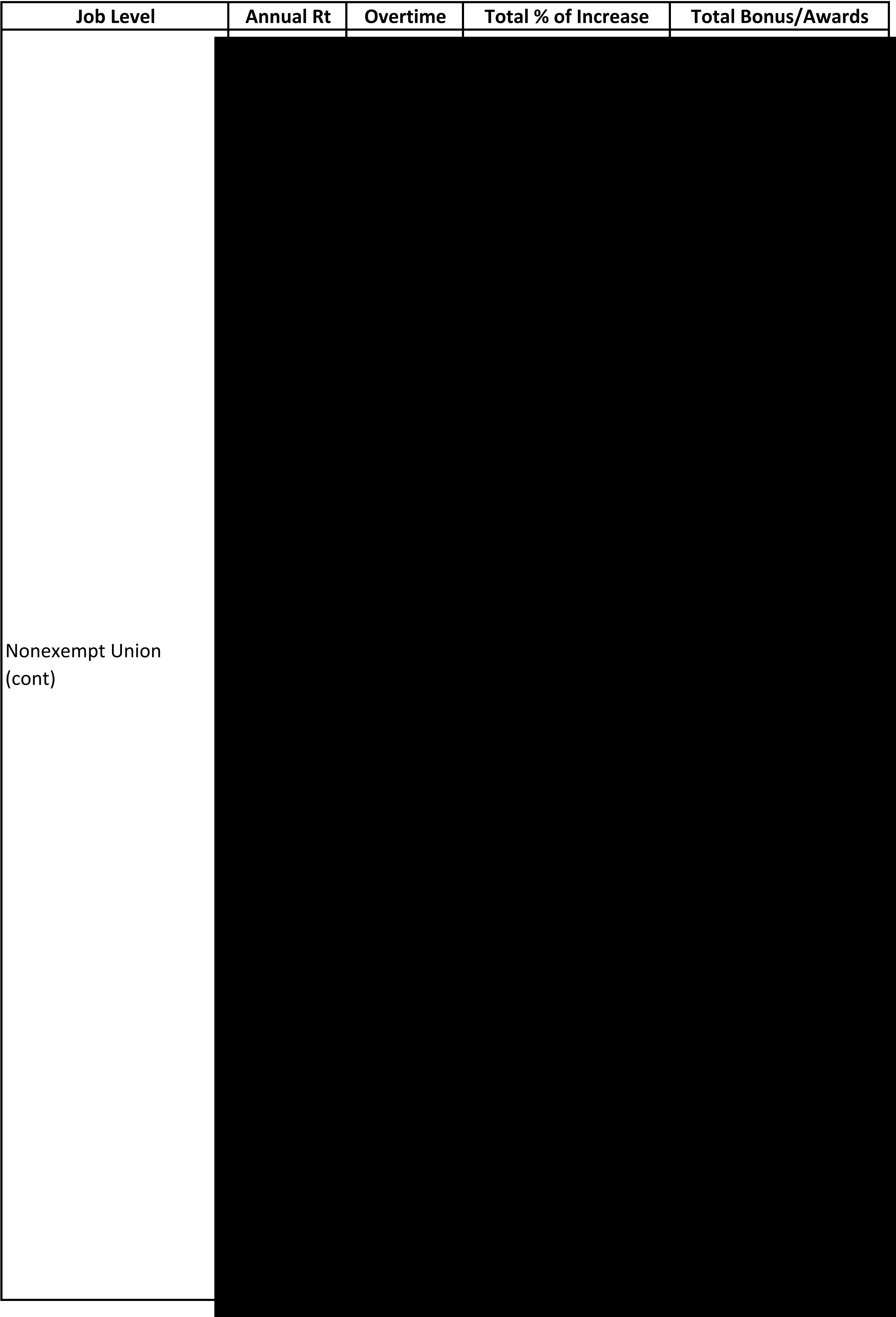




Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Nonunion				
Nonexempt Union				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

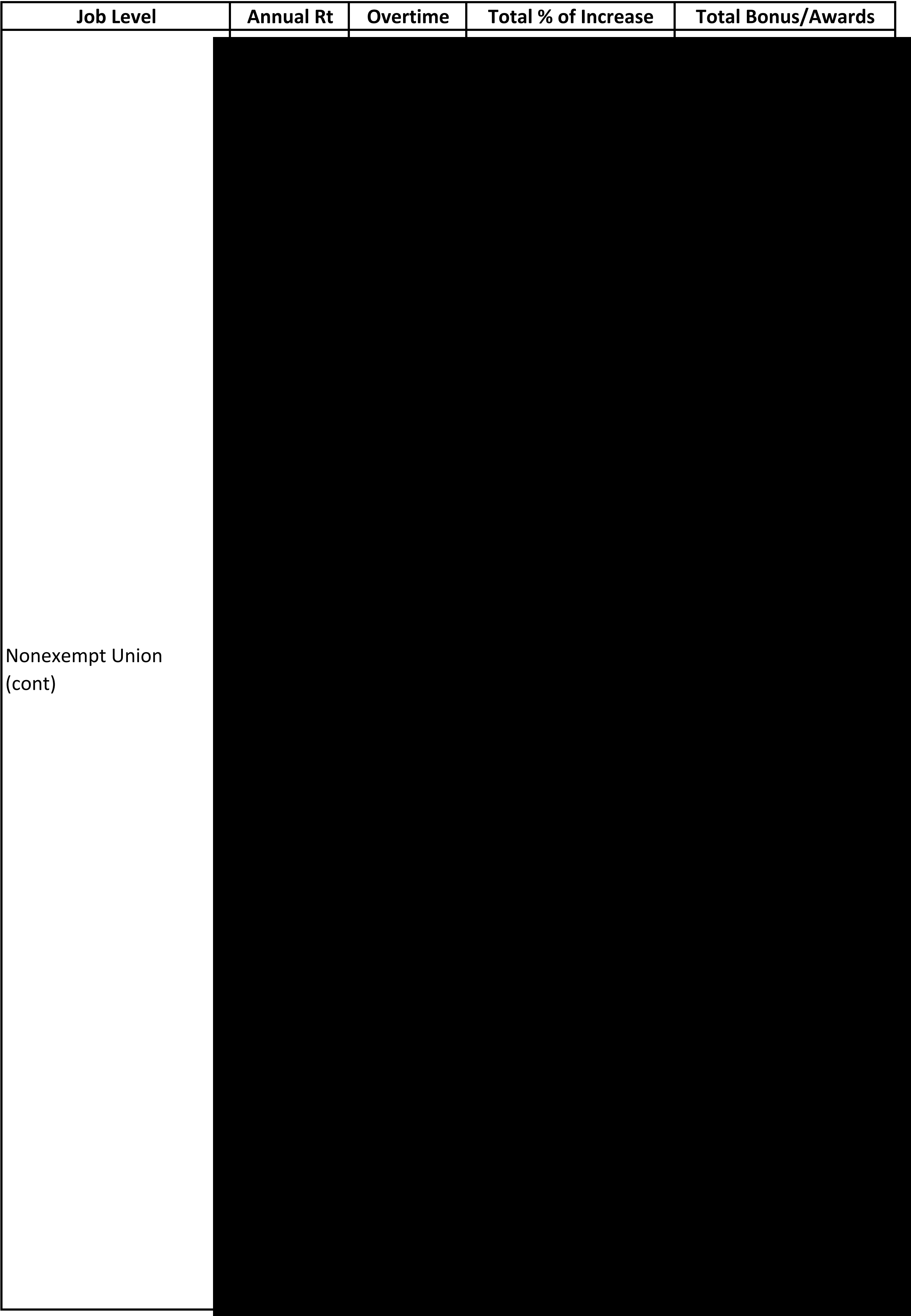


Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Nonunion				
Nonexempt Union				

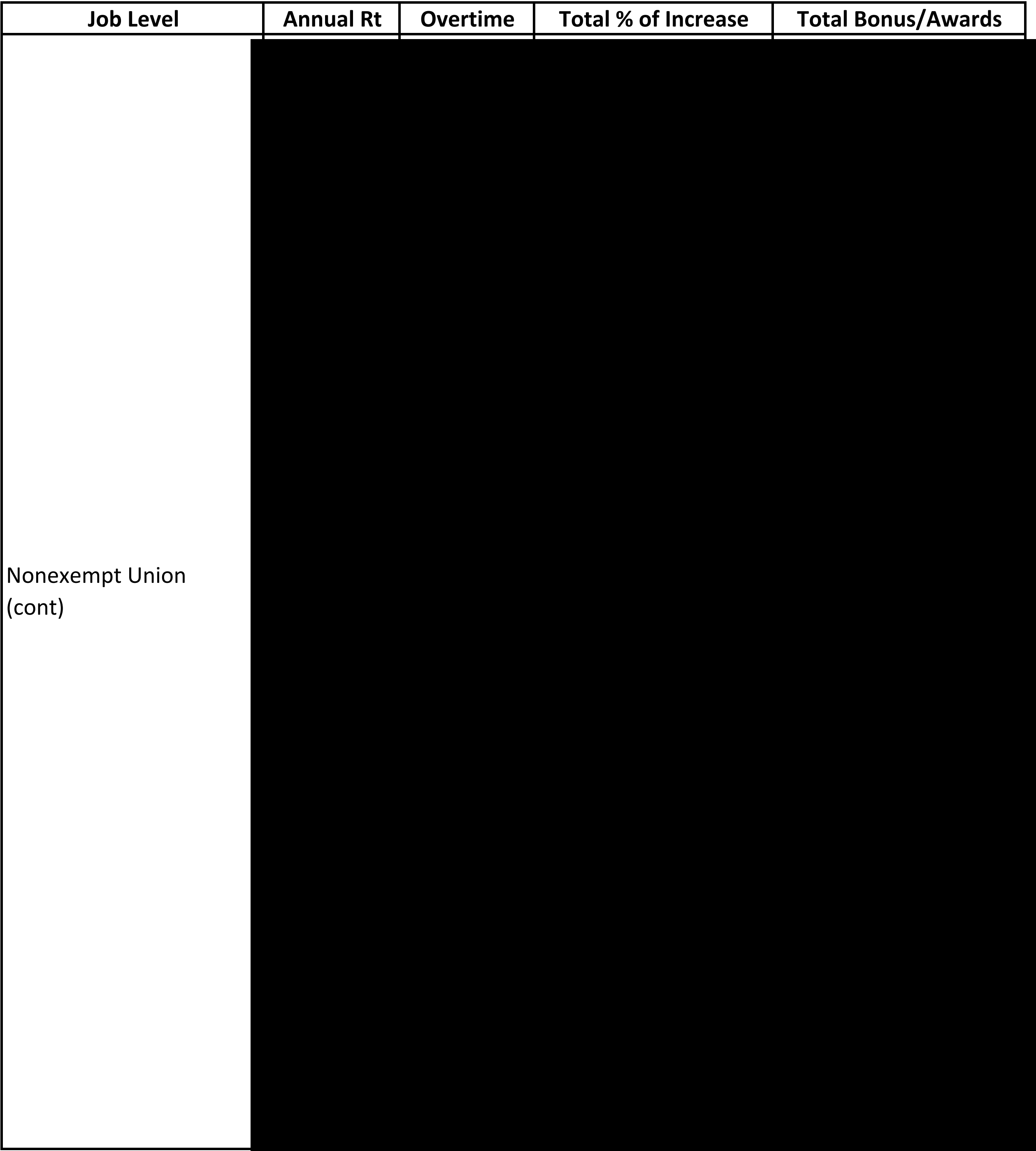
* Data as of June 30, 2016; Overtime $ is projected for 2016

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				



* Data as of June 30, 2016; Overtime $ is projected for 2016

Job Level	Annual Rt	Overtime	Total % of Increase	Total Bonus/Awards
Nonexempt Union (cont)				



* Data as of June 30, 2016; Overtime $ is projected for 2016

PSC Case No. 2016-00162
AG Set 1 DR No. 039
Attachment K

Respondent: J. T. Croom

Columbia Gas of Kentucky, Inc.
Executive Officer Compensation

	2012				2013				2014				2015				2016				Base Period			
Employee	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp
Joseph Hamrock	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	19,890	N/A	N/A	75,818	26,265	32.05%	6/1/2016	99,714	25,245	N/A	6/1/2016	99,525
Title: Chief Executive Officer																								
Effective July 2015																								
Donald Brown	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10,328	N/A	N/A	40,465	14,662	41.97%	6/1/2016	36,370	14,153		6/1/2016	36,275
Title: Chief Financial Officer																								
Effective July 2015																								
Jim Stanley	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9,308	N/A	N/A	44,950	16,511	77.39%	6/1/2016	45,869	16,256	N/A	6/1/2016	45,822
Title: Chief Operating Officer																								
Effective July 2015																								
Carrie Hightman	14,535	N/A	6/1/2012	32,645	14,535	0%	6/1/2013	32,557	14,803	1.84%	6/1/2014	37,459	14,944	0.95%	6/1/2015	38,226	14,994	0.33%	6/1/2016	36,337	14,994	N/A	6/1/2016	33,566
Title: Chief Legal Officer																								
Carl Levander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11,614	N/A	N/A	28,243	15,279	31.55%	6/1/2016	31,711	15,279	N/A	6/1/2016	31,710
Title: Chief Regulatory Officer																								
Effective July 2015																								

All Board Members are employees of NiSource. This schedule reflects only the amount charged to Columbia.

Columbia Gas of Kentucky, Inc.
Executive Officer Compensation

	2012				2013				2014				2015				2016				Base Period			
Employee	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp	Base	% Increase	Effective Date	Other Comp
Herbert Miller	198,976	N/A	6/1/2012	226,473	203,951	2.50%	6/1/2013	223,733	207,223	1.60%	6/1/2014	238,117	212,721	2.65%	6/1/2015	232,265	218,746	2.83%	6/1/2016	222,855	216,594	N/A	6/1/2016	223,092
Title: President																								
Kimra Cole	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	114,282	N/A	N/A	101,619	140,852	23.25%	6/1/2016	142,526	139,467	N/A	6/1/2016	142,266
Title: General Manager, VP of Operations																								

**COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016**

40. Reference the Columbia application generally. Provide copies of all studies that Columbia has conducted addressing the impact that the proposed rate design will have on the elderly, low income, fixed income and home bound segments of its ratepayer base. Provide detailed information for each specified group.

Response:

Columbia does not have data to segment its customers as specified. Generally, customers that consume more gas than the average will benefit with a higher increase in customer charge/lower increase in volumetric charge than customers that consume less gas, regardless if the customer is elderly, low income, fixed income or home bound or not.

For the remainder of this response, Columbia will utilize the group of its customers that were income-eligible and received LIHEAP assistance during the 12 months ending February 29, 2016. As a group, these customers are less impacted by Columbia's proposed rate design as compared to those residential customers that

did not receive LIHEAP assistance. Table 1 below compares the annual bill using the average annual usage of LIHEAP recipients and other residential customers applied to Columbia's proposed residential rates of $19.75 customer charge and $3.8668/Mcf to a revenue neutral rate design where the customer charge remains at $15.00 per month and the entire residential revenue requirement increase is included in a volumetric rate of $4.7401/Mcf. The analysis shows the average annual bill of the LIHEAP recipient customer group is $1.16 per year lower with the $19.75 customer charge than the $15.00 customer charge. The average annual bill of other residential customers is $0.33 per year greater at the $19.75 customer charge as compared to a $15.00 customer charge.[4]

Table 1: Residential Customer Average Annual Bill

	$19.75 Customer Charge $3.8668/Mcf	$15.00 Customer Charge $4.7401/Mcf	Difference
LIHEAP Recipients	$656.58/year	$657.74/year	($1.16)/year
Other Residential Customers	$646.07/year	$645.74/year	$0.33/year

[4] Usage per customer for the 12 months ending February 2016 based on actual weather. Average annual usage of LIHEAP recipients was 66.6 Mcf, other residential average annual usage was 64.9 Mcf. Amounts were calculated using rates in effect as of March 2016.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

41. Reference the Columbia application generally. Provide the general wage and salary increases that have been given, or will be given, to all Columbia's employees for each year between 2012 - 2017.

Response:

Please see table below for the general wage and salary increases that have been given, or will be given, to all Columbia's employees for each year between 2012 - 2017.

Year	Union	Nonexempt (nonunion)	Exempt
2012	2.00%	2.50%	3.00%
2013	3.00%	2.50%	3.00%
2014	2.00%	3.00%	3.00%
2015	2.00%	3.00%	3.00%
2016	*	3.00%	3.00%
2017	*	3.00%	3.00%

*Negotiations for the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers

International Union Locals 372 and 628 are scheduled for fall of 2016. Wage increases will be determined as part of the formal negotiating process and will not be known until the negotiating process is complete.

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

42. Reference the Columbia application generally. Provide the policies and procedures that Columbia relies upon when making the determination as to providing a wage and/or salary increase to an employee.

Response:

The process for determining the amount and effective date of merit increases is described below. Regarding the amount of merit increase, NCSC Human Resources analyzes projected pay increases at other utilities and general industry employers in order to keep increases in alignment with the market. Based on the results of this analysis, Human Resources recommends a percentage increase for exempt employees and non-exempt, non-union employees.

Upon approval of the percentage increase for exempt and non-union, non-exempt employees, a merit pool of dollars is established and merit increases are allocated to individual employees based upon employee performance. The effective date is June 1 of each year.

For union employees, the wage increases are based upon the terms of the bargaining unit agreement.

For all other increases, there are formal guidelines in place that provide parameters for the allowed amount of increase and approvals necessary for that increase. See attachment A to AG-1-42 for Columbia's Compensation Approval Guidelines.

Compensation Approval Guidelines as of 1/1/16

Action	Description	Approval Sequence				
		Supv/ Mgr	One Level Up	State HR Lead	SVP/ State President	VP Comp/ HR/ ER
Increase in Pay**						
Promotion	Increase in job scope level with no salary change; increase in job scope level with salary increase less than or equal to 12%; increase in job scope level with salary increase greater than 12% required to reach the salary range minimum	X	X	X		
Promotion	Promotion from non-exempt to exempt position with salary increase less than or equal to 20%	X	X			
Promotion	All Other (e.g., any increase in job scope level resulting in a pay increase greater than 12% except as described above)	X	X	X	X	X
Progression*	Move within job family; no change in job scope level: salary increase less than or equal to 6% OR progression with salary increase greater than 6% required to reach the salary range minimum	X	X			
Progression*	Move within job family; no change in job scope level: salary increase greater than 6%	X	X	X	X	X

Compensation Approval Guidelines as of 1/1/16

Action	Description	Approval Sequence				
		Supv/ Mgr	One Level Up	State HR Lead	SVP/ State President	VP Comp/ HR/ ER
Internal Equity Adjustment	Salary increase to align more closely with departmental peers; salary increase of less than or equal to 6% OR equity adjustment with salary increase greater than 6% required to reach the salary range minimum	X	X	X	X	X

**COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016**

43. Reference the Columbia application generally. Provide a detailed list of each and every raise or bonus that an employee may be entitled to, and whether or not a performance evaluation is the basis for each.

Response:

Please see the chart below for the list of each and every raise or bonus that an employee may be entitled to, and whether or not a performance evaluation is the basis for each. A "yes" in the column indicates that the increase is performance based. "No" means is it not performance based. "N/A" means not applicable. Please note that bargaining unit wages, increases, and bonuses are determined as part of the bargaining unit negotiating process.

Raise/Bonus Item	Union	Non-union
Corporate Incentive Plan	No	Yes
Spot Awards	N/A	Yes
Merit increase	N/A	Yes
Bargaining unit contractual wage increases	No	N/A
Promotional/Progression Pay Increase	N/A	Yes

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

44. Reference the Columbia application generally. Provide a detailed description of the benefits package that the Company offers its employees. Include all benefits including but not limited to health, dental, vision, disability, and life insurance plans, and include all dollar amounts paid by the employee and the employer contribution of the same. Include all relevant premiums, co-pays, deductibles, etc. Also, include 401k benefits, sick time, vacation time, overtime, etc.

Response:

See the following attachments for a detailed description of the benefits package that the Company offers its employees.

- AG 1-44 Attachment A – Health and Welfare Benefits Handbook (pre-January 1, 2013)
- AG 1-44 Attachment B - Health and Welfare Benefits Handbook (post-January 1, 2013)
- AG 1-44 Attachment C – CEG (Actives) Premiums and Contributions
- AG 1-44 Attachment D – Summary Plan Description for the Columbia Energy Group Pension Plan

- AG 1-44 Attachment E – NiSource Inc. Retirement Savings Plan
- AG 1-44 Attachment F – Vacation Policy
- AG 1-44 Attachment G – Copays and Deductibles
- AG 1-44 Attachment H – Short Term Disability

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

For Full-Time Employees in the Columbia Energy Group Bargaining Unit Hired Before January 1, 2013

Distributed: 2013
Effective January 1, 2013

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of Columbia Energy Group, an affiliate of NiSource Inc. ("NiSource" or "Company"), 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 full-time bargaining unit employees of Columbia Energy Group hired before January 1, 2013 who are covered under the Program.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the benefit plans as of January 1, 2013. 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 NiSource Benefits Committee (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 plan (identified below). *(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 – comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- 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 MySource for Human Resources, 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 MySource for Human Resources, go to the NiSource Intranet (called MySource)

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

Definitions

Unless otherwise defined in the applicable individual benefit plan section of this Handbook, 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:

"Spouse" means your lawful spouse who is also considered your spouse under the Internal Revenue Code.

"Same Sex Domestic Partner" means a person of the same sex as you, if you and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is your legal spouse or registered domestic partner, or is a party to a civil union with you, under the laws of your state of residence; or

(b) You and such person

- are both age 18 or older and competent to enter into a legal contract;
- have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are financially interdependent;
- share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in your state of residence;
- are not legally able to enter into marriage or a registered domestic partnership, or be party to a civil union, with each other under the law of your state of residence (however, if your state in the future permits same-sex marriage, civil unions or registered domestic partnerships, you must marry or enter into a civil union or registered domestic partnership within 12 months of the effective date of the new state law to retain same-sex domestic partner status);
- are not currently married to, a party to a civil union with, or the domestic partner, of any other person;
- intend that your same-sex domestic partnership be of unlimited duration; and
- do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

Notwithstanding the foregoing, for any insured benefit option, a person shall not be a same-sex domestic partner if he or she is otherwise ineligible for coverage under the terms of the certificate of coverage, group insurance policy or other governing document for such benefit option.

Please Note: From time to time, you may be required to confirm orally, electronically or in writing, in a manner prescribed by the Company, that you and your same-sex domestic partner satisfy these eligibility requirements.

"Financially interdependent" means that you and another person satisfy any two of the following conditions:

- you designate such other person as your beneficiary for employer-sponsored retirement or life insurance benefits;
- you designate such other person as your primary beneficiary under your will;
- you designate such other person as your attorney-in-fact under a durable power of attorney for health care;

- you and such other person have a common ownership or leasehold interest in real property;
- you and such other person have joint bank or credit accounts or joint investments; or
- you and such other person have joint liability for a mortgage, lease or loan.

"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.

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 MySource 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.*

Certain benefit plans are maintained pursuant to one or more collective bargaining agreements. Copies of such agreements can be obtained upon written request to the Company and copies also are available for examination at the Company's principal offices at 801 E. 86th Avenue, Merrillville, Indiana 46410, during regular business hours, and at other specified locations upon your request made in advance to your local HR representative.

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 classified as a regular full-time bargaining unit employee of Columbia Energy Group.

Your eligible dependents include:

- Your spouse, provided you are not legally separated;
- Your same-sex domestic partner;
- Your or your same-sex domestic partner's child who has not attained 26 years of age;
- Your or your same-sex domestic partner's unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) 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 terminate, (2) the child is dependent upon the employee or same-sex domestic partner for financial support and maintenance, (3) the employee continues to be covered by the Plan, (4) the child's disability continues, and (5) 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 or your same-sex domestic partner's 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 or your same-sex domestic partner would be allowed a dependent exemption for such child in computing your federal taxable income for such year. Your or your same-sex domestic partner's 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 MySource website at **www.mysourceforhr.com**, or call the MySource 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.*

Tax Treatment of Group Health Plan Coverage

Generally speaking, the cost of group health plan coverage for you, your spouse and your children who are tax dependents for health coverage purposes under the Internal Revenue Code is not taxable to you under Federal law. The Federal tax implications of covering your same-sex domestic partner and his or her eligible children under the Medical, Dental and Vision plans, however, depends on whether they qualify as your tax dependents for health coverage purposes.

Your same-sex domestic partner may qualify as your tax dependent for health coverage purposes under Federal law if

- you both have the same principal place of abode for the entire calendar year;
- your same-sex domestic partner is a member of your household for the entire calendar year;
- your relationship is not in violation of local law;
- during the calendar year you provide more than half of the total support for your same-sex domestic partner;
- your same-sex domestic partner is not your (or anyone else's) "qualifying child" for purposes of the Internal Revenue Code; and
- your same-sex domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico.

For assistance in determining whether you provide more than half of the total support for your same-sex domestic partner, consult IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

The child of your same-sex domestic partner may qualify as your tax dependent for health coverage purposes under Federal law by satisfying the test above for same-sex domestic partners or by being your "qualifying child" for purposes of the Internal Revenue Code. Note that it can be more difficult for a child of your same-sex domestic partner to satisfy the requirements for being

your tax dependent for health coverage purposes.

If your same-sex domestic partner and his or her eligible children are not your tax dependents for health coverage purposes under Federal law, your contributions toward the cost of their group health plan coverage, as well as NiSource's share of the cost of that coverage, will be treated as imputed income (i.e. included in your gross income) for tax purposes.

If an enrolled individual fails to qualify as your tax dependent for health coverage purposes under Federal law for the entire calendar year because of a change in his or her tax status during the year, then the value of the applicable coverage for the portion of the year prior to the change will be included in your gross income and related income tax and employment tax withholding will be charged as rapidly as possible. The catch-up on withholding will reduce your take-home pay for some pay periods.

State and local tax treatment of group health plan coverage for your same-sex domestic partner and his or her eligible children may differ from treatment of such coverage under Federal law.

You should consult a tax advisor for more information about the Federal, state and local tax implications of covering your same-sex domestic partner and his or her children under NiSource benefit plans.

Please Note: *If you believe that your same-sex domestic partner and his or her children qualify as your tax dependents for health coverage purposes under Federal law, you must notify MySource for Human Resources and provide any requested certifications. Otherwise, such persons will not be treated as your tax dependents for purposes of benefit plan coverage.*

Same-Sex Domestic Partner Imputed Income

NiSource will impute income for federal, state and local income tax purposes when your same-sex domestic partner or his or her children do not qualify as your tax dependents for health coverage purposes under Federal law. ***Please Note***: *NiSource will impute income for state and local income tax purposes regardless of how a state or locality taxes health coverage for your same-sex domestic partner and his or her children. (Your state or local income tax return can be adjusted to the extent your state or local tax treatment excludes the value of this coverage from gross income. You should consult with your tax advisor to discuss your particular tax situation and any questions you have about the imputation of income.)*

This means NiSource will include in your gross income the value of coverage for your same-sex domestic partner and his or her eligible children in an amount equal to the COBRA cost (minus the 2% administration fee) of You Only coverage (for coverage of your same-sex domestic partner only) or You + Children coverage (for coverage of your same-sex domestic partner and his or her children), as applicable. COBRA cost minus 2% administration fee is the total of employer plus employee premiums.

If you are on active payroll, income will be imputed and taxes will be withheld each pay period (or monthly) during the plan year.

Imputed Income Calculation Examplefor You Only Imputed Income
(Assumes coverage for you and your same-sex domestic partner only)

Employee's monthly income	$4,400
Before-tax deduction for You + Spouse	–$180* deducted for employee's + same-sex domestic partner's combined coverage
Employee's gross income (excluding imputed income)	$ 4,220
Imputed income	$400* ($400 = COBRA cost of You Only coverage minus 2%) = value of same-sex domestic partner's coverage
Gross income (including imputed income) The annual total of this amount is reported in Box 1 of your Form W-2. Income will also be reported on your W-2 for state and local income tax purposes.	$4,620

**Dollar amounts do not represent actual cost of coverage and are for illustrative purposes only.*

For further information, please call MySource for Human Resources at **1-888-640-3320**.

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, basic long-term disability, basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll, you must log on to the MySource website at **www.mysourceforhr.com** or call MySource for Human Resources 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 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 PPO 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.

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, same-sex domestic partner and/or your or your same-sex domestic partner's 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 or same-sex domestic partner 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.

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 or your same-sex domestic partner's 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 Columbia Energy Group receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

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

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

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.

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 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. **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.**

In the event your current plan coverage is not available and you fail to elect coverage under another plan that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the individual benefit plan sections of this Handbook 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, same-sex domestic partner 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 MySource for Human Resources 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 is a retiree who is covering you under the Medical Plan as a dependent, you are not entitled to an opt-out credit. You must call MySource for Human Resources 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.

If you are enrolled in the PPO option, you will receive an identification card for your medical coverage and a separate identification card for your prescription drug coverage. If you are enrolled in an HDPPO option, you will receive just one identification card that may be used for both your medical and prescription drug coverage.

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 or the individual benefit plan sections of this Handbook 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 your coverage ends on the date of your death), 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 or any applicable collective bargaining agreement;
- The last date for which any required contribution was made;
- The date on which a leave of absence begins, except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 (“FMLA”) or your employer’s personnel policies otherwise provide for continued coverage; or
- The end of the month following the date an employee terminated employment; or

A dependent shall cease to participate in the 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);
- The last date for which any required contributions for the dependent’s coverage was made;
- The end of the month following the date a dependent no longer qualifies as a dependent.

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 <u>certain</u> <u>limited</u> 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. 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 MySource for Human Resources at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event. 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, 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).
- You qualify for special enrollment in the Medical Plan 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: If you lose coverage because of an event described in item (3), your special enrollment period will be 60 days, not 31 days.*

- 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 take leave under the Family and Medical Leave Act.

Election Changes Involving Same-Sex Domestic Partners and Their Children

If your same-sex domestic partner and his or her eligible children are not your tax dependents for health coverage purposes under Federal law, they are not "dependents" for purposes of the Internal Revenue Service's rules on changing pre-tax elections discussed above.

Notwithstanding the foregoing, under certain conditions, the benefit plans will permit you to make election changes to add or drop coverage for your same-sex domestic partner and his or her eligible children who are not your tax dependents under circumstances that would permit an election change if such persons were your spouse or tax dependents. You may also make election changes to drop coverage for your same-sex domestic partner and his or her eligible children in connection with the termination of your same-sex domestic partner relationship.

To request any such election change, you must contact a customer service associate at MySource for Human Resources at **1-888-640-3320** within **31 days** of the date of the event giving rise to your request for the change. In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company or Plan Administrator.

Any election changes described above are subject to satisfaction of requirements established by the applicable benefit plan and any insurer (with respect to insured coverage). Also, no election change will be permitted that would violate requirements established by the Internal Revenue Service, as determined by the Plan Administrator or its designee in their discretion.

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. (If you become disabled, you may become Medicare-eligible before age 65.)

You should notify a MySource customer service associate if you start Medicare benefits. The way medical coverage under the benefit plans coordinates with Medicare depends on your age and whether you are an active or inactive employee.

How Coordination of Benefits Works for Active Employees

If you are an active employee or covered by another active employer plan, and 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:**
>
> If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, 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. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

If you are an active employee 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 Inactive Employees

If you are covered under the Medical Plan but are no longer considered an active employee for purposes of Medicare, and you or your spouse is 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 or your spouse becomes Medicare-eligible.

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).

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, please see below or the individual benefit plan sections of the Handbook.

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 in the applicable individual benefit plan section of the Handbook.

Claim Determination and Appeal Process – Medical and Dental Plans

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

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 that involve a rescission of coverage or 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. Solely with respect to claims involving a rescission of coverage or a determination of your eligibility under the Plan, the term "Claims Administrator" used below shall refer to the Plan Administrator.

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 or jeopardize the ability of the patient 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 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 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 MySource Participant Advocacy service through the MySource for Human Resources toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding your request to extend a course of treatment beyond what 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;
- 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 sections for the Medical Plan or Dental 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 or your coverage under the Plan should not have been rescinded. Your request must 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 in the case of the Medical Plan, and not later than 30 days after receipt of your request for review in the case of the Dental Plan.

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;
- 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.

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

The Medical 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 sections for the Medical Plan or Dental Plan, 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 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 (for the Dental 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;
- 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.

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."

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

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. A claim for benefits is incurred when the services giving rise to the claim were rendered.

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

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

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 requiring 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. Solely with respect to claims involving a determination of your eligibility under the Plan, the term "Claims Administrator" used below shall also refer to the Plan Administrator.

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 MySource Participant Advocacy service through the MySource for Human Resources toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

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 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, 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 15 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 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 Claims Administrator's 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.

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 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.

For the Vision Plan, your request for review should be sent to Claims Administrator for the Vision 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 Vision Plan. For the Health Care FSA, your request for review should be sent to the Plan Administrator at the address for the Plan Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the FSA Plan. Each of these parties are referred to below as the "reviewing authority."

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 reviewing authority 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 reviewing authority 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 reviewing authority 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 Reviewing Authority Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the reviewing authority 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 reviewing authority 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 reviewing authority 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

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.

Claim Determination and Appeal Process – Long-Term Disability and Life and AD&D Plans

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Long-Term Disability Plan and the Life and AD&D Plan. The term “Plan” as used in this section refers to the Long-Term Disability Plan or the Life and AD&D Plan, as the case may be, and the term “Claims Administrator” refers to The Prudential Insurance Company of America, with respect to the Long-Term Disability Plan, and Minnesota Life Insurance Company, with respect to the Life and AD&D Plan.

Consideration of Initial Claim

The Claims Administrator shall notify you of the claim determination within a reasonable period of time, but not later than 90 days (45 days for a disability claim) after the receipt of your claim. This period may be extended by 90 days (30 days for a disability claim) 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 (45-day period for a disability claim). For disability claims only, 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.

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,

With respect to disability claims, 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.

First Appeal to the Claims Administrator

If your claim for benefits is denied 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 your denied claim in writing to the Claims Administrator within 60 days (180 days for a disability claim) of the receipt of the written notice of denial 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, 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, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

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 for a disability claim) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days for a disability claim) 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-dayperiod (45-day period for a disability claim). 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.

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.

With respect to disability claims, 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.

Second Appeal to the Claims Administrator – Disability Claims Only

If the appeal of your benefit claim under the Long-Term Disability Plan is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in

writing to the Claims Administrator within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. 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.

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 claim on appeal is denied in whole or in part for a second time, 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 same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.

With respect to disability claims, 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.

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) for disability claims, 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.

If, after completing all the steps of the appeals process, you decide to take legal action, you must do so within three years of the end of the period within which proof of claim is required, unless otherwise provided under federal law.

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 Columbia Energy Group 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 Columbia Energy Group 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 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 **cannot** continue to participate in the Health Care FSA and/or Dependent Care FSA (Flexible Spending Accounts available under the FSA Plan) while you are receiving LTD 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"). In the event you are on FMLA leave, you must continue to make your required contribution.

The Company and Columbia Energy Group 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 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 or any applicable collective bargaining agreement.

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 COBRA-like continuation coverage made available to same-sex domestic partners, please see the section below entitled *"COBRA-Like Continuation Coverage for Same-Sex Domestic Partners."*

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 Internal Revenue 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 30 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, commencement of a proceeding in bankruptcy with respect to your employer (in the case of loss of retiree coverage), or you become 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 qualifying event occurs. This notice must be provided to MySource for Human Resources. If notice is not provided within 60 days, you will not be eligible for COBRA continuation coverage.

For notice obligations in connection with the termination of your same-sex domestic partner relationship or your same-sex domestic partner's children ceasing to be eligible under the terms of the applicable benefits plans, please see the section below entitled *"COBRA-Like Continuation Coverage for Same-Sex Domestic Partners."*

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 and during the grace period following 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 a 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*" provisions set forth below for additional information.

Coordination with HIPAA

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. The Health Insurance Portability and Accountability Act ("HIPAA") limits the extent to which employers' 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, 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 **www.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 MySource 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 MySource at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA-Like Continuation Coverage for Same-Sex Domestic Partners

Your same-sex domestic partner is not a "qualified beneficiary" for purposes of COBRA. Nevertheless, the Medical, Dental and Vision Plans and the Health Care FSA (assuming your same-sex domestic partner is your tax dependent for health coverage purposes under Federal law) will extend COBRA-like continuation coverage to your covered same-sex domestic partner and his or her covered children under circumstances in which your spouse or other dependent children would be entitled to elect COBRA. This continuation coverage will be subject to the same terms, conditions and limitations as COBRA continuation coverage that would be available to a covered spouse or other dependent children.

Without limiting the generality of the foregoing, you must notify the Plan Administrator within 60 days after the termination of your same-sex domestic partner relationship (including any termination of such relationship resulting from your same-sex domestic partner ceasing to satisfy the requirements for eligibility for coverage under the applicable benefit plans) or your same-sex domestic partner's children ceasing to be eligible under the terms of the applicable benefit plans. This notice must be provided to MySource for Human Resources. If notice is not provided within 60 days, there will no eligibility for continuation coverage.

Certificates of Group Health Coverage

If you or a covered dependent are no longer eligible for coverage under the Medical Plan, you will automatically receive a certification of group health plan coverage. A certification of group health plan coverage can be

obtained from a MySource customer service associate any time during your coverage and during the 24-month period after your coverage under the Medical Plan ends.

Additional Information

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 necessary for the benefit plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information 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 Company, 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 or arbitration, that the covered person (or his or her legal representative) receives or is entitled to receive from any of the sources listed above. 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 minor 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 those benefit plans that make use of provider networks, provider lists may be obtained, without charge, at **www.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 or Columbia Energy Group. 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. 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.

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the benefit plans, including 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 Internal Revenue 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 Administration Department and third party administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrator 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 that are self-insured, the Committee has retained a Claims Administrator to provide claim payment and other administrative services to such plans. Even though an employee may receive a benefit check from a Claims Administrator, the Company, Columbia Energy Group or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although the Claims Administrator may have insurance coverage as part of its business, the Claims Administrator is not an insurer in relation to the self-insured plans. The self-insured plans are funded from the general assets of the Company or Columbia Energy Group 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.

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.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the benefit plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

Your Medical Plan Options

NiSource Inc. (the "Company") provides eligible employees and their dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield:

- The Preferred Provider Organization (PPO), which uses the BlueCross/BlueShield Network;
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan ("Plan") may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where an HMO option is available. *If this option is available to you, you will be provided 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 Allowable Amount". Charges above the Maximum Allowable Amount are not paid by the Plan and are your responsibility. The Maximum Allowable Amount 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 Allowable 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 plans pay more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and coinsurance 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 your 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 **www.anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered through Express Scripts, Inc. ("Express Scripts"), which 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 coinsurance. These expenses are not subject to separate coinsurance 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 network, log on to **http://express-scripts.com/** or contact an Express Scripts customer service associate at the number on the back of your ID card to request assistance.

To find a provider who participates in the HDPPO network, log on to **www.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 **www.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 Services administered by Value Options. For additional details, see the section below entitled *"EAP/Work Life 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

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources 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"*.

In addition, notwithstanding the foregoing, in the event of a covered employee's death on or after January 1, 2004, coverage will continue for such employee's surviving dependents who are covered under the Plan on the date of that employee's death until the earlier of (i) the date the employee's surviving spouse or same-sex domestic partner dies, (ii) the last day of the month in which the employee's surviving spouse or same-sex domestic partner remarries or enters into a same-sex 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, and (v) with respect to any dependent, the date such dependent reaches age 65.

If a covered employee's surviving spouse or same-sex domestic partner remarries or enters into a domestic partnership or civil union with another person within the first 36 months after the employee's death, he or she may continue coverage for himself or herself and any qualified beneficiaries or covered dependents under COBRA or COBRA-like continuation coverage for the duration of the 36-month period. Also, if a covered employee's surviving spouse or same-sex

domestic partner dies within the first 36 months after the employee's death, any surviving qualified beneficiaries or covered dependents may continue coverage for themselves under COBRA or COBRA-like continuation coverage for the duration of the 36-month period. See the subsection below entitled "COBRA" for a discussion of COBRA or COBRA-like continuation coverage.

Also notwithstanding the foregoing, in the event of a covered employee's death before January 1, 2004, coverage may continue for such employee's dependents who are covered under the Plan on the date of that employee's death in accordance with a written plan or procedure, if any, applicable to such employee that was adopted by the Company and that was in effect as of December 31, 2003, as such plan or procedure was thereafter, or may hereafter, be modified by the Company.

Medical Coverage for Retirees

You are eligible for medical benefits as a retired employee if you retire with at least ten years of eligible service and you are at least 55 years of age at the time of your retirement.

Certain eligible retirees and their spouses may be entitled to receive an annual defined dollar subsidy ("Defined Dollar Subsidy") toward the cost of retiree medical coverage.

The Defined Dollar Subsidy for an eligible retiree who has not become eligible for Medicare coverage is $180 times Years of Service. The defined dollar subsidy for an eligible retiree's spouse (or same-sex domestic partner, provided the eligible retiree retired on or after February 1, 2013) who has not become eligible for Medicare coverage is $125 times Years of Service.

The Defined Dollar Subsidy for an eligible retiree who has become Medicare-eligible is $60 times Years of Service. The defined dollar subsidy for an eligible retiree's spouse (or same-sex domestic partner, provided the eligible retiree retired on or after February 1, 2013) who has become eligible for Medicare coverage is $40 times Years of Service.

In addition to the Defined Dollar Subsidy, an eligible retiree may receive a monthly payment of $37.50 as a Medicare Part B reimbursement.

If an eligible retiree dies prior to his or her spouse, the surviving spouse may receive a Defined Dollar Subsidy in the same amount as the eligible retiree, as if the eligible retiree were the same age as the surviving spouse. This benefit is also available to the same-sex domestic partner of an eligible retiree who retired on or after February 1, 2013.

For purposes of the Defined Dollar Subsidy, "Years of Service" means the total number of Years of Service, rounded up to the nearest whole number, earned by the eligible retiree for purposes of benefit accrual (including all service prior to a distribution that causes any prior service to be disregarded) under each defined benefit pension plan maintained by the Company or an affiliate in which the eligible retiree accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan.

You must notify the Company of your planned retirement, at which time you will receive further information regarding your retiree benefits. Retiree benefits are not described in this Handbook. Generally, if you are under age 65, you are eligible to elect the same Medical Plan options that are available to active employees. If you or your spouse (or same-sex domestic partner, provided you retired on or after February 1, 2013) is over age 65, there are different plans that may be available to you and your spouse or same-sex domestic partner, depending upon the terms of the collective bargaining agreement in place at the time you retire. For further information about your benefit or to notify the Company of your retirement, contact MySource at **1-888-640-3320**.

Subject to the terms of any applicable collective bargaining agreement, the Committee reserves the right to terminate, change or modify any retiree benefits at any time without the consent of, or advance notice to, you or your covered dependents.

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, coinsurance 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	$400 per covered member	$800 per covered member
Covered Member + Spouse	$400 per covered person	$800 per covered person
Covered Member + child(ren)	$400 per covered person, up to a total of $800	$800 per covered person, up to a total of $1,600
Covered Member + Family (spouse + children)	$400 per covered person, up to a total of $1,200	$800 per covered person, up to a total of $2,400
Office Visit Co-Pay/Coinsurance	$30	60% after deductible
Specialist Office Visit Co-Pay/Coinsurance	$35	60% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, deductibles, co-pays, balanced billed charges and expenses not covered under Plan)		
Covered Member	$1,000	$2,000
Covered Member + Spouse	$2,000	$4,000
Covered Member + Child(ren)	$2,000	$4,000
Covered Member + Family	$3,000	$6,000

**Please Note*:* *Where applicable, coverage categories include eligible same-sex domestic partner and eligible children of same-sex domestic partner.*

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 visits 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. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	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)

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	**Plan Pays**
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after in-network deductible)
Second Surgical Opinions	100% (after $30 co-pay per office visit)	60% (after deductible)
Professional Services (Outpatient)		
	100%, (after $35 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)
Emergency Care Services		
Accident (True Emergencies)	100% (after $100 co-pay)	100% (no co-pay or deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $30 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	100% (after $35 co-pay per office visit)	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 $35 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $35 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	100% (no co-pay or 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 member generally must satisfy the "individual" covered member deductible requirement (currently $400 for in-network and $800 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered member 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, $800 for covered member + spouse or for covered member + child(ren), or $1,200 for covered member + family), additional covered members 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 $400 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 member must satisfy the $400 in-network deductible requirement before the "family" deductible requirement is met.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, coinsurance 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	$1,500	$2,500	$2,500
Covered Member + Spouse	$3,000	$3,000	$5,000	$5,000
Covered Member + Child(ren)	$3,000	$3,000	$5,000	$5,000
Covered Member + Family	$3,000	$3,000	$5,000	$5,000

FEATURE*	HDPPO 1		HDPPO 2	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Coinsurance				
	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	$4,500	$5,000	$7,500
Covered Member + Spouse	$6,000	$9,000	$10,000	$15,000
Covered Member + Child(ren)	$6,000	$9,000	$10,000	$15,000
Covered Member + Family	$6,000	$9,000	$10,000	$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	

**Please Note*: *Where applicable, coverage categories include eligible same-sex domestic partner and eligible children of same-sex domestic partner.*

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options.

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**
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)	80% (after deductible)	80% (after deductible)	80% (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	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)				
	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.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for medically necessary eligible expenses up to the maximum allowance. *For services covered under an HMO plan, please refer to the HMO SPD.*

The covered expenses under the medical 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 36 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. In some instances, the Plan may extend the limits based on medical necessity.

- 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);
  - 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 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 visits 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

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.

Notwithstanding the foregoing, regardless of whether you currently exhibit symptoms or have been diagnosed with a medical condition, the Plan pays benefits for one in-network mammography and one in-network colonoscopy per covered person per calendar year with no deductibles, co-payments or coinsurance.

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 recommend 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 coinsurance. Additional preventive health services furnished by out-of-network providers are subject to deductibles and coinsurance under the PPO option, but are covered by the Plan with no deductible, co-payments or coinsurance 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 coinsurance 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 coinsurance.

Recommended preventive health services fall under four broad categories, described below, that are specified in federal regulations regarding coverage of preventive health services:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer;
  - Cervical cancer;
  - Colorectal cancer;
  - High Blood Pressure;
  - Type 2 Diabetes Mellitus;
  - Cholesterol;
  - Child and Adult Obesity;
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Women's contraceptives, sterilization procedures and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants;
  - Breastfeeding support, supplies and counseling. Benefits for breast pumps are limited to one per Plan Year; and
  - Gestational diabetes screening.

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins after the date the recommendations or guidelines are issued and will not remain covered services after the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services.

Please note that 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, coinsurance 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, coinsurance and/or deductible for the office visit.

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these services (or you may view the federal government's web sites, **http://www.healthcare.gov/center/regulations/prevention.html**; **http://www.ahrq.gov/clinic/uspstfix.htm**; or **http://www.cdc.gov/vaccines/recs/acip/**.)

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your spouse, your same-sex domestic partner and your or your same-sex domestic partner's

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 or your same-sex domestic partner's female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call MySource for Human Resources at **1-888-640-3320**, or log on to the MySource for Human Resources website at **www.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 Allowable 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, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320.**

Medical Expenses Not Covered

The medical expenses **not** covered include, but may not be limited to the following:

- Any condition, disease, defect, ailment, or injury that arises out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive benefits in whole or in part. It also applies whether or not you claim the benefits or compensation, and regardless of whether you recover benefits from any third party.
- Expenses for which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if you had applied for Part A and/or Part B (except as specified elsewhere under the Plan or as otherwise prohibited by federal law).
- Charges related to cosmetic surgery or related hospital admissions, unless made necessary:
  - By an injury;
  - For correction of congenital deformity when necessary to perform a normal body function;
  - For reconstructive surgery as necessary for the prompt treatment of a diseased condition.
- Any service or supply that is related to weight loss or the treatment of obesity (except for the surgical treatment of morbid obesity).
- Services associated with the treatment of infertility, including: artificial insemination; fertilization (such as in-vitro or GIFT); procedures and tests related to fertilization; and infertility drugs and related services that follow the diagnosis of infertility.
- Care received in an emergency room that is not considered emergency care (except as specified under the plan).
- Services or supplies that you receive at a health spa or similar type of facility.
- Self-help training and other forms of non-medical self care (except as provided under the plan).
- Radial keratotomy or keratomileusis, or excimer laser photo refractive keratectomy.
- Speech therapy, unless the therapy is expected to restore speech to a person who has lost speech function as a result of a disease or injury.
- Surgical-related expenses associated with Norplant and IUDs, elective abortions, or reverse sterilization.
- Custodial care, or for services received in an uncertified skilled nursing facility.
- Pre-admission testing if you decide to postpone your surgery.
- Dental implants.
- The Plan limits benefits for home health care services.
- Professional services when related to Depo-Provera injections or routine vision exams.
- Hospice care benefits for:
  - Home-delivered meals or homemaker services;
  - Respite care;
  - Traditional medical services to treat the terminal illness, disease, or condition;
  - Transportation, including – but not limited to – ambulance transportation; and
  - Care provided by a family member or friend.
- Human organ transplant benefits for the following:
  - Cardiac rehabilitation services provided more than three days after the recipient is discharged from the hospital;
  - Transportation by air ambulance for the donor or the recipient;
  - Travel time (and related expenses) required by a provider; or
  - Drugs that are experimental or investigational in nature.
- Dental appliances (except for intra-oral devices used in connection with the temporomandibular joint dysfunction

treatments) or the replacement of cataract lenses when a prescription change is not required.

- Orthotics when used for comfort only.
- Any cutting procedure in the mouth (except when performed in connection with the removal of non-impacted teeth, replacement of teeth, dentures or appliances, orthodontia or periodontia, alveoplasty, or the repair or preparation of the mouth to receive or maintain dentures).
- Charges that are not for the care or treatment of an injury or sickness, except as specifically provided for by the Plan.
- Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for oral surgery for repair of injury to natural teeth, or as provided herein.
- Charges for the non-surgical treatment of temporomandibular joint (TMJ) dysfunction except for the appliance.
- Charges for or related to some services, treatment, education testing or training related to learning disabilities or developmental delays.
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease.
- Charges related to services provided by the United States government, any state government, or any government outside the United States in which the participant or dependent is entitled to receive benefits. An exception to this exclusion applies for services provided by the United States government that can be billed to the Plan under COBRA.
- Charges that a covered person is not legally required to pay and charges that would not have been made if the Plan had not existed.
- Charges that exceed reasonable and customary charges or the Maximum Allowable Amount or are not medically necessary.
- Charges that are reimbursed, or that could be reimbursed, by any public program other than Medicaid, Medicare or TRICARE.
- Charges for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy.
- Charges for marriage, family, child, career, social adjustment, pastoral and financial counseling, except as provided by the EAP.
- Charges for acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery that is covered under the Plan.
- Charges for biofeedback services.
- Charges for examinations related to employment.
- Charge for examinations related to marriage.
- Charges for eye surgery performed primarily to correct refractive errors.
- Charges for experimental or investigational services. These include treatments, procedures, equipment, drugs, devices or supplies that in the judgment of the Claims Administrator are experimental or investigational for the diagnosis for which the person is being treated, and services not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator. They also include any services related to such treatments, procedures, equipment, drugs, devices or supplies, regardless of when incurred.
- Charges for chiropractic maintenance care.
- Charges for transportation to and from places of treatment and care, other than ambulance service when medically necessary.
- Charges related to any services or supplies for counseling related to sexual dysfunctions or inadequacies.
- Charges incurred prior to the effective date of coverage, or after the termination date of coverage.
- Charges for services rendered by a relative of the participant, or any other person who

resides in the same household as the participant.

- Charges incurred for the treatment of a sickness or injury as a result of any act of war, declared or undeclared.
- Charges incurred as a result of any act of rioting or civil disobedience.
- Court-ordered testing or care.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Missed or cancelled appointments.
- Mileage costs or travel expenses unless authorized by the Plan.
- Charges for custodial care, domiciliary or convalescent care, except as otherwise provided in the Plan.
- Charges for eyeglasses or contact lenses, except for the first pair of eyeglasses or contact lenses prescribed following cataract surgery.
- Charges for sex transformation surgery and related services, or the reversal thereof.
- Charges for reversal of sterilization.
- Charges for elective sterilization procedures for someone other than the participant or his or her spouse.
- Personal hygiene and convenience items.
- Charges for examinations relating to research screenings.
- Stand-by charges of a physician.

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 Express Scripts. 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 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 Express Scripts 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 Express Scripts otherwise.

The PPO coverage option also utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Express Scripts 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 Express Scripts toll-free at 1-855-846-6774.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a prescribed brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the

brand-name drug), and if you request that the brand-name drug be dispensed, you will be responsible for the applicable co-pay plus the difference in cost between the brand-name drug and the generic substitute, unless your prescribing physician indicates that the brand-name drug is to be "dispensed as written."

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a 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.

If you fill your prescription at a nonparticipating pharmacy, the Plan pays the cost of the drug less the co-pay. The co-pay requirement applies to each original prescription or refill. If your physician authorizes a prescription refill, you must bring the prescription bottle or package to the participating pharmacy.

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 Express Scripts' 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 ***Express Scripts*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Prescription Order Form and your check to:
  Express Scripts, Inc.
  PO Box 66558
  St. Louis, MO 63166-6558

- 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 Express Scripts Network, contact Express Scripts at the number on the back of your ID card. Or you can log on to the Express Scripts website at **http://express-scripts.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	$15 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	$40 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	$90 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		
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 (coinsurance), or a set co-pay amount (not both). If your percentage of the cost results in an amount that is* ***less than* *the "minimum co-pay," you pay the minimum co-pay amount. If your percentage of the cost results in an amount that is* ***greater than*** *the "maximum co-pay," you pay up to the maximum co-pay amount. For the PPO Coverage Option, if you request that a brand-name drug be dispensed instead of its generic substitute, you may be responsible for paying the difference between the cost of the brand-name drug and the generic substitute, in addition to the applicable co-pay.*

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 coinsurance. These expenses are not subject to separate coinsurance 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.

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 coinsurance 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 **www.anthem.com**.

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 coinsurance.
- Mail the Prescription Order Form and your check to the address on the mail 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 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 **www.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.

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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**	
	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
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
	Retail Pharmacy		**Mail Order**	
Day Supply Limit	30-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		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.

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;
- 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;
- Vitamins (unless prescribed);
- 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 the following: 1) Mental Health and Substance Use Disorder Coverage, and 2) Employee Assistance Program (EAP)/Work Life Services benefits. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life Services benefits are administered by Value 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 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 the following 1) Mental Health and Substance Use Disorder Coverage, and 2) Employee Assistance Program (EAP)/Work Life Services benefits. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life Services benefits are administered through Value 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 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	OUT-OF-NETWORK
	Plan Pays	**Plan Pays***
Mental Health Inpatient	80% (after deductible)	60% (after deductible)
Mental Health Outpatient	100% (after $30 co-pay)	60% (after deductible)
Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
Substance Use Disorder (Detox Outpatient)	100% (after $30 co-pay)	60% (after deductible)
Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
Substance Use Disorder (Rehab Outpatient)	100% (after $30 co-pay)	60% (after deductible)

**For out-of-network providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowable Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowable Amount. As a result you are responsible for any charges that exceed the Maximum Allowable 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.

MENTAL HEALTH AND SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK*
	Plan Pays (after deductible)	**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 Allowable Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowable Amount. As a result you are responsible for any charges that exceed the Maximum Allowable Amount.*

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 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 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 Services

Value Options offers you and your family information, resources and referrals on certain life issues that you may be facing. Issues such as:

- Finding child care

- Depression and anxiety
- Marital and family concerns
- Adopting a child
- Workplace concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and Financial Issues

Value Options' professional staff is available 24 hours a day, seven days a week at **1-800-946-5360**. Counselors will help you define your needs, provide counseling and support, and then carry out an extensive search for information and services compatible with your family's preferences and finances. Their service is free and confidential. If needed, the counselor will assist you in setting up an in-office visit with a Value Options EAP counselor in your area. You, a family member, or a household member may receive up to six free EAP sessions at no cost with the local EAP counselor.

You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If you need additional legal or financial assistance, your EAP counselor will refer you to an attorney or financial counselor in your community.

Counselors work hard to find resources that fit your budget requirements. If your Value Options EAP counselor provides a referral for services beyond the six free EAP visits, you are responsible for the cost of the care selected.

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 becomes entitled to Medicare due to end-stage renal disease, 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 payer of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

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 from the Claims Administrator by phone via MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website **www.mysourceforhr.com**.
- 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 MySource for Human Resources 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 – Medical and Dental Plans."*

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 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.

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;

Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

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:	Self-Funded. 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.
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) 647-5571**
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. 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 and Mental Health and Substance Use Disorders:	Anthem Insurance Companies, Inc. P.O. Box 37010 Louisville, KY 40233 **www.anthem.com** **1-800-228-2891**

Claims Administrator for EAP:	Value Options P.O. Box 1347 Latham, NY 12110-8847 **www.valueoptions.com** **1-800-946-5360**
Claims Administrator for Prescription Drug Service:	Express Scripts, Inc. (PPO) **http://express-scripts.com/** **1-855-846-6774** **1-800-899-2114** (TDD) *Mailing Address for Prescriptions (PPO)* Express Scripts, Inc. PO Box 66558 St. Louis, MO 63166-6558 *For Paper Claims (PPO)*: Express Scripts, Inc. ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872 *For Clinical Appeals (PPO):* Express Scripts, Inc. Attn: Pharmacy Appeals - KJJ Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439 Fax (877) 852-4070 The Anthem Prescription Drug Program (HDPPO 1 and HDPPO 2) P.O. Box 746000 Cincinnati, OH 45274-6000 **www.anthem.com** **1-800-228-2891** (mail order) **1-800-228-2891** (customer service)
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

Dental Plan

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Your Dental Plan Options

NiSource Inc. (the "Company") offers the NiSource Dental Plan (the "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 MySource for Human Resource website at **www.mysourceforhr.com** or call the MySource 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

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources 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	
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.

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
<u>Initial Installment</u>	
CIGNA Allowable (25% of total)	1,250.00
CIGNA Payment (50% of Allowable)	625.00
<u>Remaining Installments</u>	
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 MySource for Human Resources 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 **<u>not</u>** 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 MySource for Human Resources 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 June 15 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 MySource for Human Resources website **www.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 MySource for Human Resources 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 – Medical and Dental Plans."*

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 participating employers, through participant contributions and 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) 647-5571**
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 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 **www.cigna.com**
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

Vision Plan

Your Vision Plan Options

NiSource Inc. (the "Company") offers the NiSource Vision Plan (the "Plan") to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

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 doctors. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP network doctor or a non-VSP provider. However, if you go to a VSP 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 Network Doctor** – 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 and eyewear from a VSP network provider, you are responsible for the amount in excess of the Plan's allowance, or 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 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 doctor who participates in the VSP Network, log on to the MySource for Human Resources website at **www.mysourceforhr.com** or call MySource 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

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources at **1-888-640-3320** or log on to the MySource for Human Resources website at **www.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 NETWORK PROVIDER	NON-VSP PROVIDER
Exam			
	Once every calendar year	100%	Up to a $35 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $25 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $40 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $55 allowance
Lenticular	Once every calendar year	100%	Up to a $80 allowance
Frame			
	One every two consecutive calendar years	100%, Up to a $180 frame allowance	Up to a $45 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 $150 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts and contact lens exam (fitting and evaluation). The contact lens exam is in addition to your vision exam to ensure proper fit of contacts.

Basic Vision Option

COVERED SERVICES	FREQUENCY	VSP NETWORK PROVIDER	NON-VSP PROVIDER
Exam			
	Once every calendar year	100%	Up to a $35 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*."

The services and materials that the Plan covers include, but are not limited to, the following:

- One vision exam in every calendar year.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame, one pair in every two consecutive calendar year period (up to the frame allowance).
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the cost of your eye exam, contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of lenses.

Extra Discounts and Savings

When visiting a VSP network provider, you may receive:

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives;
- 20% off additional prescription glasses and sunglasses;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent children;
- 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. Visit the Claims Administrator's website at **www.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 MySource for Human Resources at **1-888-640-3320**.

Vision Expenses Not Covered

The Plan pays benefits for many vision care services and eyewear. However, some limits and exclusions do apply. If you want to know if a service or eyewear will be covered under the Plan, or if you have questions regarding your coverage, please ask your VSP provider or call the Claims Administrator.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the covered member will pay the additional costs for the options.

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Progressive multifocal lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care.

Not Covered

There are no benefits for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses;
- Two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under the Plan that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- Services and/or eyewear not indicated as covered Plan benefits.

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 services (i.e., any amounts that exceed the Plan's specified allowances). You must incur eligible expenses no later than March 15 following the end of the Plan Year and submit them to the Health Care Flexible Spending Account no later than June 15 following the end of the Plan Year. Please see the "Flexible Benefits Plan" section of this Handbook for additional details about the Health Care Flexible Spending Account.

Coordination of Benefits (COB)

If you or your dependents have vision coverage under another plan, the primary plan is the one under which you are covered as an employee. Eligible dependent children receive primary coverage under their father's plan.

If your secondary plan pays the out-of-pocket expenses you incur under your primary plan, the following rules apply:

- The deductible (if any) under the secondary plan is waived;
- Payment under the secondary plan is made directly to you (according to the secondary plan's non-network provider schedule); and
- Any payment made toward a service or material that is covered under the secondary plan exhausts the secondary plan's coverage for that service for the entire benefit period.

If the primary plan already pays for a service or eyewear within the allowed period and you use a VSP network provider (in-network) under the secondary plan for that same service, the service is provided based on the secondary plan's preferred care provider schedule. In this case, deductible amounts (if any) toward that service apply under the secondary plan.

If you have primary coverage under another carrier, the Plan provides secondary coverage based on the coordination of benefits rules outlined in the "*Coordination of Benefits*" section of the **Benefits Program Overview**.

If you do not use the secondary plan to recover out-of-pocket expenses incurred under the primary plan, you can use the secondary plan for another claim (provided such services have been exhausted under the primary plan).

How to Access the Vision Benefits

Selecting a VSP Network Provider

- Log on to the MySource for Human Resources website at **www.mysourceforhr.com** to find the link to VSP's website that houses the most up-to-date list of VSP network providers; or call MySource for Human Resources at **1-888-640-3320** to locate a VSP network provider near you. Call the VSP 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 claim form. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete your portion of the claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the MySource for Human Resources website **www.mysourceforhr.com** and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bill should include:
  - Name of patient;
  - Patient's relationship to you;
  - Patient's date of birth;
  - Name and Social Security number of employee;
  - Provider's bill; and
  - Copy of your itemized paid receipt (you can forward this to the Claims Administrator without a completed claim form as long as you include your name and social security number, the patient's name and relationship to you, and the patient's date of birth).

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Be sure to submit your completed claim to the Claims Administrator within six months 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 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 MySource for Human Resources 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 – 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 Inc. 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) 647-5571**
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 Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 **www.vsp.com**
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 997105 Sacramento, CA 95899-7105
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670

Agent for Service of Legal Process: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, Indiana 46410
(219) 647-5571

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

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.

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 FSA 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 $2,500 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.

For reimbursement of health care expenses incurred by your same-sex domestic partner and his or her eligible children, see *"Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children"* below.

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 Internal Revenue 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

You can elect to participate in the FSA Plan provided you are classified as a regular full-time employee and your collective bargaining agreement provides for your eligibility in the FSA Plan.

For reimbursement under the Health Care FSA of health care expenses incurred by your same-sex domestic partner and his or her eligible children, see *"Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children"* below.

For purposes of the Dependent Care FSA, 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.

For reimbursement of expenses incurred by your same-sex domestic partner and his or her eligible children, see "Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children" below.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section of the FSA Plan, you can 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 "*Enrollment*" section and the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

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 $2,500	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). For reimbursement of expenses incurred by your same-sex domestic partner and his or her eligible children, see "Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children" below.	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 Internal Revenue 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. • 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.	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.

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 Internal Revenue 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. 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 the Claims Administrator via MySource for Human Resources 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:

- Over the counter medications (other than insulin) obtained without a prescription;
- 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.

Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children

If your same-sex domestic partner and his or her eligible children qualify as your tax dependents for health coverage purposes under the Internal Revenue Code, then you may pay for eligible health care expenses incurred by them with funds from your Health Care FSA. For a discussion of when your same-sex domestic partner or his or her eligible children may qualify as your tax dependents, see the subsection of the **Benefits Program Overview** entitled “Tax Treatment.”

If, at some point during the plan year, you terminate your same-sex domestic partner relationship, or your same-sex domestic partner or his or her children otherwise cease to meet eligibility requirements, then your same-sex domestic partner and/or his or her children will not be considered tax dependents for any part of the plan year. In that case, any reimbursement for health care expenses incurred by your same-sex domestic partner or his or her children prior to the termination of your relationship will have been inappropriate and may need to be repaid to your account or offset against future submitted claims. You should consult with a tax advisor if you have any questions about the tax implications of covering your same-sex domestic partner and his or her children under a Health Care FSA.

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. If you do not incur enough expenses to use all of the funds in your Health Care FSA by the end of the year, you may use an additional "grace period" (from January 1 until March 15) to incur expenses for the previous year's balance. You then have until June 15 to submit claims for expenses you incur between January 1 and December 31 plus the grace period.

Example: To show how you might use your Health Care FSA, assume that you elect to put $1,200 in your Health Care FSA for 2013. By December 31 you have incurred only $1,000 in eligible expenses. You have until March 15, 2014 (the end of the grace period) to incur additional expenses, and must submit all claims for your 2013 Health Care FSA by June 15, 2014.

Any health care expense incurred after March 15 will not be considered eligible for reimbursement from the prior year's funding. In addition, all expenses incurred between the previous January 1 and December 31 or during the grace period that follows must be submitted for payment no later than June 15.

Please note: *If you maintain a Health Care FSA during the current Plan Year and you want to participate in a high deductible health plan and contribute to a health savings account (HSA) during the next Plan Year, you must reduce the balance in your Health Care FSA (determined on a cash basis) to zero on or before December 31 of the current Plan Year. Pending claims, claims submitted, claims received, or claims under review that have not been paid as of December 31 are not taken into account in determining whether your Health Care FSA has a zero balance. If you fail to reduce the balance in your Health Care FSA to zero on or before December 31 of the current Plan Year, you may not contribute to an HSA until April 1 of the following year.*

Reimbursement Claims

A form can be obtained online via the MySource for Human Resources website **www.mysourceforhr.com**, or call the Claims Administrator via the MySource for Human Resources toll-free number **1-888-640-3320** to request a form.

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
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

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 not use your debit card to obtain reimbursement for over the counter medications, even if you have a prescription for such medications.

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 the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

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.

To obtain reimbursement for an expense, complete and submit a dependent care reimbursement form. A form can be obtained online via the MySource for Human Resources website **www.mysourceforhr.com**, or by calling the Claims Administrator via the MySource for Human Resources toll-free number **1-888-640-3320** to request a form.

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
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

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 June 15 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31), plus the grace period (January 1 through March 15 of the following year). 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 June 15 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 June 15 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). **The "grace period" does not apply to the Dependent Care FSA.** 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 June 15 will be forfeited.

Claim Determination and Appeal Process

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 for the Dependent Care FSA

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.

If, after completing all the steps of the claims procedure process, you decide to take legal action, you must do so within three years of the day the charge or claim is incurred.

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 Aon Hewitt. The participating employers have 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 Internal Revenue Code) for you, your spouse or dependents (as defined in Section 223 of the Internal Revenue 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, your Employer may make a monthly 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 each year is governed by federal law. Please call MySource for Human Resources 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 most retiree medical insurance or other qualified medical expenses on a tax-free basis, or you can take a distribution, subject to income tax.

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

You can elect to contribute to an HSA if you are a regular full-time employee 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 Internal Revenue Code.

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

If you cover your same-sex domestic partner under HDPPO 1 or HDPPO 2, you are generally entitled to make contributions to your HSA up to the limit established for family coverage.

The special rule that limits the amount of HSA contributions by individuals who are married to each other when one spouse has family coverage does not apply to you and your same-sex domestic partner.

For information regarding reimbursement of qualified medical expenses for your same-sex domestic partner and his or her eligible children, see *"Reimbursement of HSA Qualified Medical Expenses for Same-Sex Domestic Partners and Their Children"* below.

Enrollment

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

Please note: *If you had a Health Care FSA (or any other health flexible spending account with a grace period feature) during the previous Plan Year and the balance in your account was not reduced to zero by December 31 of that Plan Year, you may not contribute to an HSA until April 1 of the following year.*

When Coverage Begins and Ends

Coverage Begins

You may enroll in the Health Savings Account (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 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.

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 Internal Revenue Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay tax on the account distribution as well as a 20% penalty. If a distribution is made after age 65, after disability, or after death, the distribution will be subject to 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 ***www.irs.gov****.*

Reimbursement of HSA Qualified Medical Expenses for Same-Sex Domestic Partners and Their Children

If your same-sex domestic partner and his or her eligible children qualify as your tax dependents under the Internal Revenue Code, without taking into account their gross income, then you may pay for qualified medical expenses incurred by them with funds from your HSA. Note, however, that the extension of coverage to children until age 26, an important feature of health care reform, does not apply to HSAs; accordingly, reimbursement of such "adult children's" qualified medical expenses from your HSA on a tax-free basis is not permitted.

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, Aon Hewitt 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 Aon Hewitt. 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.

Please note: *You may not use your HSA debit card to pay for over-the-counter medications, even though you may have a prescription for such medications.*

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 MySource for Human Resources website **www.mysourceforhr.com** or call MySource for Human Resources 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.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**
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.
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 Aon Hewitt, 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:	Aon Hewitt 2300 Discovery Drive Orlando, FL 32826 **www.mysourceforhr.com**

Claims Administrator for Health Savings Accounts:	Aon Hewitt 2300 Discovery Drive Orlando, FL 32826 **www.mysourceforhr.com**
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

Long-Term Disability Plan

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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 MySource for Human Resources 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

You are eligible to participate in the Plan if you are a regular full-time employee of Columbia Energy Group who is covered by a collective bargaining agreement between Columbia Energy Group and a union and who regularly works 40 or more hours per week. Your eligibility for optional, contributory coverage may be subject to your satisfying other requirements established by Prudential. Refer to the Group Insurance Certificate for more details.

Information regarding eligibility can be accessed through the MySource website at **www.mysourceforhr.com** or by calling the MySource automated telephone system at **1-888-640-3320** to speak to a service representative.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section immediately 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.)

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 or as otherwise required by a collective bargaining agreement. *If you have questions regarding the amount of your required contributions, please contact MySource for Human Resources at **1-888-640-3320**.*

When Coverage Begins and Ends

Coverage Begins

Coverage under the Basic LTD Coverage Option of the Plan generally may become effective on (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) your first day of active employment for regular new hires, if you apply within 31 days of such date, (2) 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 (3) the date the Plan approves such enrollment due to a qualified life event.

Notwithstanding the foregoing, all employees must be in active employment in order for any coverage initially to become effective and for any subsequent Plan changes to take effect.

Coverage Ends

The coverage 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 Contract 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 or any applicable collective bargaining agreement;
- 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.

Highlights of the Long-Term Disability Plan Coverage

The following charts provide examples illustrating 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. The following are provided for illustrative purposes only and shall be construed in manner consistent with the terms of the Group Contract and your Group Insurance Certificate. In the event of a conflict between the following and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

If you are Disabled and Not Working

To show how your Monthly Benefit is calculated, let's assume that your monthly pre-disability earnings ("Monthly Earnings") equal $3,000, and that you qualify for a monthly Social Security Disability Benefit of $500. Here is how the Plan calculates your Monthly Benefit under both coverage options.

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

For example:

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Monthly Earnings*	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (Monthly Earnings times Percentage of Coverage) (A x B)	$1,500	$1,800
D	70% of your Monthly Earnings Less Deductible Sources of Income	$2,100 - 500 $1,600	$2,100 - 500 $1,600
E	**Monthly Benefit**** (Lesser of C or D)	**$1,500**	**$1,600**

**Your Monthly Earnings are indexed as provided in the Group Insurance Certificate.*

***The minimum monthly payment is the greater of (a) $100 or (b) 10% of your Gross Disability Payment. Prudential may apply this amount toward an outstanding overpayment. See "Taxability of Monthly Benefits" below for information regarding the taxability of monthly benefits you receive under the Plan.*

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 following examples show how your Monthly Benefit is calculated if you are working while you are disabled and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings.

First 12 months

To show how your Monthly Benefits are calculated during the first 12 months you are disabled and working and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings, assume that your Indexed Monthly Earnings are $3,000. Assume further that your Disability Earnings are $1,000, and that you are not receiving any other deductible sources of income. Here is how the Plan calculates your benefits under both coverage options:

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Indexed Monthly Earnings	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (Monthly Earnings times Percentage of Coverage) (A x B)	$1,500	$1,800
D	Monthly Payment (Gross Disability Payment minus Deductible Sources of Income, if any)*	$1,500 - 0 $1,500	$1,800 - 0 $1,800
E	Add Disability Earnings and Gross Disability Payment to determine if the sum exceeds Indexed Monthly Earnings	$1,000 +1,500 $2,500 (does not exceed $3,000)	$1,000 +1,800 $2,800 (does not exceed $3,000)
F	Subtract the amount that Disability Earnings plus the Gross Disability Payment exceeds Monthly Earnings (E - A, if > 0) from the Monthly Payment in D to determine the Monthly Benefit	$1,500 - 0 $1,500	$1,800 - 0 $1,800
G	**Monthly Benefit****	**$1,500**	**$1,800**

**Deductible sources of income are subtracted only if the Percentage of Coverage is 70%*

***See "Taxability of Monthly Benefits" below for information regarding the taxability of monthly benefits you receive under the Plan.*

After First 12 months

To show how your Monthly Benefit is calculated after the first 12 months you are disabled and working and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings, assume that your Indexed Monthly Earnings are $3,000 and your Disability Earnings are $2,000. Assume also that you do not qualify for Social Security Disability Benefits. Here is how the Plan calculates your Monthly Benefit under both coverage options.

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Indexed Monthly Earnings	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment(*A x B*)	$1,500	$1,800
D	Your Indexed Monthly Earnings less your Disability Earnings	$3,000 - 2,000 $1,000	$3,000 - 2,000 $1,000
E	Lost earnings percentage calculation	$1,000 = .33 $3,000	$1,000 = .33 $3,000
F	Gross Disability Payment less any Deductible Sources of Income*	$1,500 - 0 $1,500	$1,800 - 0 $1,800
G	**Monthly Benefit *(E x F)*****	**33% x $1,500 = $500**	**33% x $1,800 = $600**

**Deductible sources of income are subtracted only if the Percentage of Coverage is 70%*

***See "Taxability of Monthly Benefits" below for information regarding the taxability of monthly benefits you receive under the Plan.*

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.

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 who are on layoff or leave of absence or 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; (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, or (iii) any loss of time disability payments under the United States Social Security Act or any similar plan or act, (b) any retirement payments you receive under the United States Social Security Act or any similar plan or act, or (c) amounts you receive as disability payments, that you voluntarily elect to receive as retirement or early retirement payments, or that you receive as retirement payments when you reach normal retirement age, under your Employer's retirement plan. 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 will not be included as disability earnings since 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 for 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 includes 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 NiSource 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 Internal Revenue 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

Your maximum period of payment 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 MySource for Human Resources 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.

For purposes of this Plan, the term "spouse" includes your same-sex domestic partner, as that term is defined in the **Benefits Program Overview.**

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 MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website at **www.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 and Life and AD&D Plans."*

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 MySource for Human Resources.

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

You cannot continue to make contributions to the Health 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. If you return to work, your original contribution election is amortized over the remaining pay periods for the calendar year.

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

While you are receiving Plan benefits, you are not entitled to receive any employer contributions to an HSA, nor may you contribute to an HSA by means of payroll deduction.

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 **www.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) 647-5571**
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 51 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, PA 19176
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

The Group Contract underwritten by The Prudential Life 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 MySource automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

The Prudential Life 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 Insurance Plan

Your Life Insurance and AD&D Options

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan (the "Plan") to eligible employees with the following coverage options (each a "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

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 ("Minnesota Life"), who is the 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 MySource for Human Resources 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

Employees

You are eligible to participate in the Plan if you (i) are a regular full-time employee of Columbia Energy Group who is covered by a collective bargaining agreement between Columbia Energy Group and a union, (ii) regularly work 40 or more hours per week or at least the number of hours per week set forth in your collective bargaining agreement as being the minimum necessary to be classified as a full-time employee entitled to benefits under the Plan, 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 Minnesota Life.

See the individual benefit plan sections below and refer to the Group Insurance Certificate for further details.

Eligible Dependents

If you are eligible to participate in the Plan, you may obtain certain coverage for your "eligible dependents." Your "eligible dependents" are:

- Your lawful spouse; and
- Your unmarried children from live birth to the end of the month in which the unmarried child attains age 26; and

For purposes of this Plan, the term "spouse" or "lawful spouse" includes your same-sex domestic partner, as that term is defined in the **Benefits Program Overview**.

Your "children" include: (1) your or your same-sex domestic partner's natural children, legally adopted children and children placed

with you or your same-sex domestic partner for adoption prior to legal adoption; and (2) each of your or your same-sex domestic partner's stepchildren, foster children, children subject to legal guardianship, grandchildren, and other children who are blood relatives who depend on you or your same-sex domestic partner for more than fifty percent of their support and maintenance. A child placed with you or your same-sex domestic partner 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 or your or your same-sex domestic partner, as the case may be.

Notwithstanding the foregoing, your or your same-sex domestic partner's 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 Note: It is your responsibility to advise MySource when a person is no longer eligible for coverage as an eligible dependent under the Plan. Any amounts paid on behalf of a person who is no longer an eligible dependent will be required to be repaid to the Plan.

*Information regarding eligibility can be accessed through the MySource website at **www.mysourceforhr.com** or by calling the MySource automated telephone system at **1-888-640-3320** to speak to a service representative.*

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option. If you desire coverage as a newly eligible employee, you must enroll in the Optional Employee Term Life Coverage Option, the Dependents Term Life Coverage Option, the Supplemental Employee AD&D Coverage Option and the Dependents AD&D Coverage Option (collectively the "Optional Coverages") within 31 days of your date of hire or the date you become newly eligible. If you do not enroll in an Optional Coverage 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 Minnesota Life. *You may obtain enrollment forms by contacting MySource for Human Resources at **1-888-640-3320***

In general, once you enroll in (or decline) any of the Optional Coverages, 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. If any change in coverage is subject to evidence of insurability, Minnesota Life must decide that such

evidence is satisfactory. (Please see the "*Enrollment*" and the "*Changing and Continuing Elections*" section of the **Benefits Program Overview** for further details.) *To obtain the necessary forms for enrolling in, or changing, your Optional Coverages, please contact MySource for Human Resources at **1-888-640-3320**.*

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option. If you elect any of the Optional Coverages, you will pay for the cost of such coverage. *If you have questions regarding the amount of your required contributions, please contact MySource for Human Resources at **1-888-640-3320**.*

When Coverage Begins and Ends

Coverage Begins

Provided you have satisfied the eligibility requirements described above, coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the 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 Coverages 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 Optional Employee Term Life Coverage, 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 Certificate, 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 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 Dependents Term Life Coverage, you are covered under Employee Term Life Coverage, and for Dependents AD&D Coverage, you are covered under Supplemental Employee AD&D Coverage), (4) for Dependents Term Life Coverage, 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 Optional Employee Term Life Coverage. 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 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 Minnesota Life, 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 Insurance or Dependents Insurance under a Coverage Option will end when the first of these occurs:

- The date as of which the Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Coverage Option, the date a Coverage Option is terminated;
- The date that the 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 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 Insurance will not cause your Employee Insurance to end;
- For Dependents Term Life Coverage, the date your Employee Term Life Coverage ends;
- For Dependents AD&D Coverage, the date your Supplemental Employee AD&D Coverage ends;
- For Dependents 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 Employee Optional Coverage, the last day for which premium contributions have been made following your written request to end any Employee Optional Coverage.
- For Dependents Insurance, the last day for which premium contributions have been made following your written request to end Dependents Insurance for an "eligible dependent"

You must notify the Claims Administrator when a dependent is no longer eligible for coverage under the Plan so that premiums may be discontinued.

If your Employee Insurance coverage 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 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.

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 Coverage Option. You can obtain a beneficiary form by calling MySource at **1-888-640-3320**. Minnesota Life has prepared information about the modes of settlement that are available. For further information, contact MySource at **1-888-640-3320**.

The Group Insurance Certificate also contains rules regarding the assignment of your insurance under a Coverage Option. Refer to the Group Insurance Certificate for the terms and conditions under which such assignments may be made.

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. 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 "Terminal Illness Proceeds" paid under the Option to Accelerate Payment of Death Benefits.

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 insurance is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit is $1,500,000 minus the amount of your insurance under the Basic Employee Term Life Coverage Option. Amounts otherwise payable as benefits will be reduced by the amount of any "Terminal Illness Proceeds" 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 Minnesota Life 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 Optional Employee Term Life Coverage 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 Optional Employee Term Life Coverage 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 Optional Employee Term Life Coverage 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 Optional Employee Term Life Coverage, 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 Term Life Coverage 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 Minnesota Life.

Any new enrollment or requested increase in coverage that is subject to evidence of insurability will become effective when Minnesota Life 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 Minnesota Life decides the evidence is satisfactory and you are actively at work.

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 Death Benefit paid to you in one full sum when Minnesota Life receives proof that you have a Terminal Condition.

Benefits otherwise payable under the Employee Term Life Insurance upon your death and any amount that could otherwise have been converted to an individual contract will be reduced by the Accelerated Death Benefit.

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) Your Employee Term Life Insurance must not be assigned; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance ; (5) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this option; and (6) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this option.

You have a "Terminal Condition" if you have a condition caused by sickness or accident which directly results in a life expectancy of twelve months or less. "Accelerated Death Benefit" means the amount of your Employee Term Life Insurance that Minnesota Life will pay if you are eligible under this option. The Accelerated Death Benefit is equal to 100% of the amount in force on your life on the date Minnesota Life receives the proof that you have a Terminal Condition, but not more than $1,000,000. The minimum death benefit eligible for an Accelerated Death Benefit is $10,000. Minnesota Life 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.

If you elect to accelerate your death benefit and the termination of your coverage causes an eligible dependent to lose 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 death benefit payable under the Accelerated Death Benefit Option, your Employee Term Life Insurance coverage (reduced by the amount of the Accelerated Death Benefit) will continue after your election of the Accelerated Death Benefit Option and your premiums will be reduced accordingly. The amount of the Accelerated Death 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 made under this option 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; or
- If your spouse previously did not meet a requirement for evidence of insurability under any Minnesota Life group contract for the participating employer.

Option 3 spousal coverage will become effective on the first day date Minnesota Life decides the evidence is satisfactory. 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.

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 Minnesota Life'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 Minnesota Life receives written proof as described above.

Death Benefits under the Employee Term Life Coverage are payable according to Minnesota Life's beneficiary and mode of settlement rules. Death benefits under the Dependents Term Life Coverage 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 Dependents Term Life Coverage 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 Minnesota Life 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 Minnesota Life 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 Basic and Supplemental Employee and Dependents AD&D Coverage 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 Minnesota Life 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.

Portability of Life and AD&D Coverage

If coverage under any of the Coverage Options ceases, you may have the right to apply for coverage for yourself or for your "eligible dependent," as the case may be, under a Portability Plan maintained by Minnesota Life. 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.

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 Coverage and Dependents Term Life Coverage, except that you or your "eligible dependent," as the case may be, may convert the amount of insurance under the Employee Term Life Coverage or Dependents Term Life Coverage 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 Minnesota Life 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 or same-sex domestic partner. 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 or same-sex domestic partner.

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 Minnesota Life. 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 or same-sex domestic partner 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 same-sex domestic partner 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, Dependent Child Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Can a retiree convert or port coverages?	Yes	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. Minnesota Life will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Minnesota Life Contacts	Minnesota Life Insurance Company 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company 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, Minnesota Life 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 Coverage 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 Minnesota Life. Claim forms can be obtained from Minnesota Life by phone via MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website at **www.mysourceforhr.com**. If you do not receive the form from Minnesota Life within 15 days of your request, send Minnesota Life 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 – Long-Term Disability and Life and AD&D Plans."*

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) 647-5571**
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 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

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. 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 MySource automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Minnesota Life 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.

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Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

For Full-Time Employees in the Columbia Energy Group Bargaining Unit Hired on or After January 1, 2013

Distributed: 2013
Effective January 1, 2013

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Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

As an employee of Columbia Energy Group, an affiliate of NiSource Inc. ("NiSource" or "Company"), 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 full-time bargaining unit employees of Columbia Energy Group hired on or after January 1, 2013 who are covered under the Program.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the benefit plans as of January 1, 2013. 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 NiSource Benefits Committee (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 plan (identified below). *(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 – comprised of the "FSA Plan" and provisions for contributions to Health Savings Accounts, or "HSAs")
- 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 MySource for Human Resources, 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 MySource for Human Resources, go to the NiSource Intranet (called MySource) and log on to the secure website at

www.mysourceforhr.com. MySource can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the MySource automated telephone system at **1-888-640-3320.**

Definitions

Unless otherwise defined in the applicable individual benefit plan section of this Handbook, 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:

"Spouse" means your lawful spouse who is also considered your spouse under the Internal Revenue Code.

"Same Sex Domestic Partner" means a person of the same sex as you, if you and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is your legal spouse or registered domestic partner, or is a party to a civil union with you, under the laws of your state of residence; or

(b) You and such person

- are both age 18 or older and competent to enter into a legal contract;
- have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are financially interdependent;
- share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in your state of residence;
- are not legally able to enter into marriage or a registered domestic partnership, or be party to a civil union, with each other under the law of your state of residence (however, if your state in the future permits same-sex marriage, civil unions or registered domestic partnerships, you must marry or enter into a civil union or registered domestic partnership within 12 months of the effective date of the new state law to retain same-sex domestic partner status);
- are not currently married to, a party to a civil union with, or the domestic partner, of any other person;
- intend that your same-sex domestic partnership be of unlimited duration; and
- do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

Notwithstanding the foregoing, for any insured benefit option, a person shall not be a same-sex domestic partner if he or she is otherwise ineligible for coverage under the terms of the certificate of coverage, group insurance policy or other governing document for such benefit option.

Please Note: From time to time, you may be required to confirm orally, electronically or in writing, in a manner prescribed by the Company, that you and your same-sex domestic partner satisfy these eligibility requirements.

"Financially interdependent" means that you and another person satisfy any two of the following conditions:

- you designate such other person as your beneficiary for employer-sponsored retirement or life insurance benefits;
- you designate such other person as your primary beneficiary under your will;
- you designate such other person as your attorney-in-fact under a durable power of attorney for health care;
- you and such other person have a common ownership or leasehold interest in real property;

— you and such other person have joint bank or credit accounts or joint investments; or

— you and such other person have joint liability for a mortgage, lease or loan.

"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.

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 MySource 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.*

Certain benefit plans are maintained pursuant to one or more collective bargaining agreements. Copies of such agreements can be obtained upon written request to the Company and copies also are available for examination at the Company's principal offices at 801 E. 86th Avenue, Merrillville, Indiana 46410, during regular business hours, and at other specified locations upon your request made in advance to your local HR representative.

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 classified as a regular full-time bargaining unit employee of Columbia Energy Group.

Your eligible dependents include:

- Your spouse, provided you are not legally separated;
- Your same-sex domestic partner;
- Your or your same-sex domestic partner's child who has not attained 26 years of age;
- Your or your same-sex domestic partner's unmarried child who satisfies the dependency test below and who is incapable of self-sustaining employment due to mental or physical disability if: (1) 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 terminate, (2) the child is dependent upon the employee or same-sex domestic partner for financial support and maintenance, (3) the employee continues to be covered by the Plan, (4) the child's disability continues, and (5) 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 or your same-sex domestic partner's 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 or your same-sex domestic partner would be allowed a dependent exemption for such child in computing your federal taxable income for such year. Your or your same-sex domestic partner's 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 MySource website at ***www.mysourceforhr.com****, or call the MySource 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.*

Tax Treatment of Group Health Plan Coverage

Generally speaking, the cost of group health plan coverage for you, your spouse and your children who are tax dependents for health coverage purposes under the Internal Revenue Code is not taxable to you under Federal law. The Federal tax implications of covering your same-sex domestic partner and his or her eligible children under the Medical, Dental and Vision plans, however, depends on whether they qualify as your tax dependents for health coverage purposes.

Your same-sex domestic partner may qualify as your tax dependent for health coverage purposes under Federal law if

- you both have the same principal place of abode for the entire calendar year;
- your same-sex domestic partner is a member of your household for the entire calendar year;
- your relationship is not in violation of local law;
- during the calendar year you provide more than half of the total support for your same-sex domestic partner;
- your same-sex domestic partner is not your (or anyone else's) "qualifying child" for purposes of the Internal Revenue Code; and
- your same-sex domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico.

For assistance in determining whether you provide more than half of the total support for your same-sex domestic partner, consult IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

The child of your same-sex domestic partner may qualify as your tax dependent for health coverage purposes under Federal law by satisfying the test above for same-sex domestic partners or by being your "qualifying child" for purposes of the Internal Revenue Code. Note that it can be more difficult for a child of your same-sex domestic partner to satisfy the requirements for being your tax dependent for health coverage purposes.

If your same-sex domestic partner and his or her eligible children are not your tax dependents for health coverage purposes

under Federal law, your contributions toward the cost of their group health plan coverage, as well as NiSource's share of the cost of that coverage, will be treated as imputed income (i.e. included in your gross income) for tax purposes.

If an enrolled individual fails to qualify as your tax dependent for health coverage purposes under Federal law for the entire calendar year because of a change in his or her tax status during the year, then the value of the applicable coverage for the portion of the year prior to the change will be included in your gross income and related income tax and employment tax withholding will be charged as rapidly as possible. The catch-up on withholding will reduce your take-home pay for some pay periods.

State and local tax treatment of group health plan coverage for your same-sex domestic partner and his or her eligible children may differ from treatment of such coverage under Federal law.

You should consult a tax advisor for more information about the Federal, state and local tax implications of covering your same-sex domestic partner and his or her children under NiSource benefit plans.

Please Note: *If you believe that your same-sex domestic partner and his or her children qualify as your tax dependents for health coverage purposes under Federal law, you must notify MySource for Human Resources and provide any requested certifications. Otherwise, such persons will not be treated as your tax dependents for purposes of benefit plan coverage.*

Same-Sex Domestic Partner Imputed Income

NiSource will impute income for federal, state and local income tax purposes when your same-sex domestic partner or his or her children do not qualify as your tax dependents for health coverage purposes under Federal law. ***Please Note***: *NiSource will impute income for state and local income tax purposes regardless of how a state or locality taxes health coverage for your same-sex domestic partner and his or her children.* *(Your state or local income tax return can be adjusted to the extent your state or local tax treatment excludes the value of this coverage from gross income. You should consult with your tax advisor to discuss your particular tax situation and any questions you have about the imputation of income.)*

This means NiSource will include in your gross income the value of coverage for your same-sex domestic partner and his or her eligible children in an amount equal to the COBRA cost (minus the 2% administration fee) of You Only coverage (for coverage of your same-sex domestic partner only) or You + Children coverage (for coverage of your same-sex domestic partner and his or her children), as applicable. COBRA cost minus 2% administration fee is the total of employer plus employee premiums.

If you are on active payroll, income will be imputed and taxes will be withheld each pay period (or monthly) during the plan year.

Imputed Income Calculation Example for You Only Imputed Income

(Assumes coverage for you and your same-sex domestic partner only)

Employee's monthly income	$4,400
Before-tax deduction for You + Spouse	–$180* deducted for employee's + same-sex domestic partner's combined coverage
Employee's gross income (excluding imputed income)	$ 4,220
Imputed income	$400* ($400 = COBRA cost of You Only coverage minus 2%) = value of same-sex domestic partner's coverage
Gross income (including imputed income) The annual total of this amount is reported in Box 1 of your Form W-2. Income will also be reported on your W-2 for state and local income tax purposes.	$4,620

**Dollar amounts do not represent actual cost of coverage and are for illustrative purposes only.*

For further information, please call MySource for Human Resources at **1-888-640-3320**.

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, basic long-term disability, basic life and basic AD&D coverages upon the date you become eligible for such coverage.

To enroll, you must log on to the MySource website at **www.mysourceforhr.com** or call MySource for Human Resources 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 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 PPO 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.

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, same-sex domestic partner and/or your or your same-sex domestic partner's 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 or same-sex domestic partner 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.

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 or your same-sex domestic partner's 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 Columbia Energy Group receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

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

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

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.

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 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. **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.**

In the event your current plan coverage is not available and you fail to elect coverage under another plan that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the individual benefit plan sections of this Handbook 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, same-sex domestic partner 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 MySource for Human Resources 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 is a retiree who is covering you under the Medical Plan as a dependent, you are not entitled to an opt-out credit. You must call MySource for Human Resources 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.

If you are enrolled in the PPO option, you will receive an identification card for your medical coverage and a separate identification card for your prescription drug coverage. If you are enrolled in an HDPPO option, you will receive just one identification card that may be used for both your medical and prescription drug coverage.

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 or the individual benefit plan sections of this Handbook 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 your coverage ends on the date of your death), 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 or any applicable collective bargaining agreement;
- The last date for which any required contribution was made;
- The date on which a leave of absence begins, except to the extent continuation coverage is required by the Family and Medical Leave Act of 1993 (“FMLA”) or your employer’s personnel policies otherwise provide for continued coverage; or
- The end of the month following the date an employee terminated employment; or

A dependent shall cease to participate in the 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);
- The last date for which any required contributions for the dependent’s coverage was made;
- The end of the month following the date a dependent no longer qualifies as a dependent.

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. 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 MySource for Human Resources at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event. 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, 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).
- You qualify for special enrollment in the Medical Plan 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: If you lose coverage because of an event described in item (3), your special enrollment period will be 60 days, not 31 days.*

- 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 take leave under the Family and Medical Leave Act.

Election Changes Involving Same-Sex Domestic Partners and Their Children

If your same-sex domestic partner and his or her eligible children are not your tax dependents for health coverage purposes under Federal law, they are not "dependents" for purposes of the Internal Revenue Service's rules on changing pre-tax elections discussed above.

Notwithstanding the foregoing, under certain conditions, the benefit plans will permit you to make election changes to add or drop coverage for your same-sex domestic partner and his or her eligible children who are not your tax dependents under circumstances that would permit an election change if such persons were your spouse or tax dependents. You may also make election changes to drop coverage for your same-sex domestic partner and his or her eligible children in connection with the termination of your same-sex domestic partner relationship.

To request any such election change, you must contact a customer service associate at MySource for Human Resources at **1-888-640-3320** within **31 days** of the date of the event giving rise to your request for the change. In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company or Plan Administrator.

Any election changes described above are subject to satisfaction of requirements established by the applicable benefit plan and any insurer (with respect to insured coverage). Also, no election change will be permitted that would violate requirements established by the Internal Revenue Service, as determined by the Plan Administrator or its designee in their discretion.

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. (If you become disabled, you may become Medicare-eligible before age 65.)

You should notify a MySource customer service associate if you start Medicare benefits. The way medical coverage under the benefit plans coordinates with Medicare depends on your age and whether you are an active or inactive employee.

How Coordination of Benefits Works for Active Employees

If you are an active employee or covered by another active employer plan, and 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:

If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, 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. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

If you are an active employee 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 Inactive Employees

If you are covered under the Medical Plan but are no longer considered an active employee for purposes of Medicare, and you or your spouse is 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 or your spouse becomes Medicare-eligible.

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).

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, please see below or the individual benefit plan sections of the Handbook.

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 in the applicable individual benefit plan section of the Handbook.

Claim Determination and Appeal Process – Medical and Dental Plans

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Medical Plan and the Dental Plan. The term "Plan" as used in this section refers to the Medical Plan or the Dental Plan, 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 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.

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 that involve a rescission of coverage or 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. Solely with respect to claims involving a rescission of coverage or a determination of your eligibility under the Plan, the term "Claims Administrator" used below shall refer to the Plan Administrator.

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 or jeopardize the ability of the patient 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 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 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 MySource Participant Advocacy service through the MySource for Human Resources toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

Generally, a "concurrent care claim" is any claim involving a decision to reduce or

terminate an ongoing course of treatment or a decision regarding your request to extend a course of treatment beyond what 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;
- 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 sections for the Medical Plan or Dental 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 or your coverage under the Plan should not have been rescinded. Your request must 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 in the case of the Medical Plan, and not later than 30 days after receipt of your request for review in the case of the Dental Plan.

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;
- 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.

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

The Medical 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 sections for the Medical Plan or Dental Plan, 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 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 (for the Dental 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;
- 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.

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."

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

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. A claim for benefits is incurred when the services giving rise to the claim were rendered.

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

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Vision Plan and the Health Care FSA. The term "Plan" as used in this section refers to 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.

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 requiring 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. Solely with respect to claims involving a determination of your eligibility under the Plan, the term "Claims

Administrator" used below shall also refer to the Plan Administrator.

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 MySource Participant Advocacy service through the MySource for Human Resources toll-free number (**1-888-640-3320**) for more information.

Concurrent Care Claims

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 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, 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 15 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 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 Claims Administrator's 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.

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 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.

For the Vision Plan, your request for review should be sent to Claims Administrator for the Vision 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 Vision Plan. For the Health Care FSA, your request for review should be sent to the Plan Administrator at the address for the Plan Administrator set forth in the section entitled "General Program Information" found in the individual SPD sections for the FSA Plan. Each of these parties are referred to below as the "reviewing authority."

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 reviewing authority 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 reviewing authority 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 reviewing authority 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 Reviewing Authority Makes an Adverse Benefit Determination on Your Second-Level Appeal

If the reviewing authority 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 reviewing authority 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 reviewing authority 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

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.

Claim Determination and Appeal Process – Long-Term Disability and Life and AD&D Plans

Unless otherwise noted, the claim determination and appeal process described below applies to each of the Long-Term Disability Plan and the Life and AD&D Plan. The term "Plan" as used in this section refers to the Long-Term Disability Plan or the Life and AD&D Plan, as the case may be, and the term "Claims Administrator" refers to The Prudential Insurance Company of America, with respect to the Long-Term Disability Plan, and Minnesota Life Insurance Company, with respect to the Life and AD&D Plan.

Consideration of Initial Claim

The Claims Administrator shall notify you of the claim determination within a reasonable period of time, but not later than 90 days (45 days for a disability claim) after the receipt of your claim. This period may be extended by 90 days (30 days for a disability claim) 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 (45-day period for a disability claim). For disability claims only, 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.

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,

With respect to disability claims, 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.

First Appeal to the Claims Administrator

If your claim for benefits is denied 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 your denied claim in writing to the Claims Administrator within 60 days (180 days

for a disability claim) of the receipt of the written notice of denial 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, 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, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

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 for a disability claim) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days for a disability claim) 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-dayperiod (45-day period for a disability claim). 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.

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.

With respect to disability claims, 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.

Second Appeal to the Claims Administrator – Disability Claims Only

If the appeal of your benefit claim under the Long-Term Disability Plan is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to the Claims Administrator within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. 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.

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 claim on appeal is denied in whole or in part for a second time, 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 same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.

With respect to disability claims, 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.

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) for disability claims, 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.

If, after completing all the steps of the appeals process, you decide to take legal action, you must do so within three years of the end of the period within which proof of claim is required, unless otherwise provided under federal law.

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 Columbia Energy Group 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 Columbia Energy Group 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 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 **cannot** continue to participate in the Health Care FSA and/or Dependent Care FSA (Flexible Spending Accounts available under the FSA Plan) while you are receiving LTD 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"). In the event you are on FMLA leave, you must continue to make your required contribution.

The Company and Columbia Energy Group 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 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 or any applicable collective bargaining agreement.

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 COBRA-like continuation coverage made available to same-sex domestic partners, please see the section below entitled *"COBRA-Like Continuation Coverage for Same-Sex Domestic Partners."*

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 Internal Revenue 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 30 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, commencement of

a proceeding in bankruptcy with respect to your employer (in the case of loss of retiree coverage), or you become 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 qualifying event occurs. This notice must be provided to MySource for Human Resources. If notice is not provided within 60 days, you will not be eligible for COBRA continuation coverage.

For notice obligations in connection with the termination of your same-sex domestic partner relationship or your same-sex domestic partner's children ceasing to be eligible under the terms of the applicable benefits plans, please see the section below entitled *"COBRA-Like Continuation Coverage for Same-Sex Domestic Partners."*

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 and during the grace period following 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 a 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*" provisions set forth below for additional information.

Coordination with HIPAA

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. The Health Insurance Portability and Accountability Act ("HIPAA") limits the extent to which employers' 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, 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 **www.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 MySource 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 MySource at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA-Like Continuation Coverage for Same-Sex Domestic Partners

Your same-sex domestic partner is not a "qualified beneficiary" for purposes of COBRA. Nevertheless, the Medical, Dental and Vision Plans and the Health Care FSA (assuming your same-sex domestic partner is your tax dependent for health coverage purposes under Federal law) will extend COBRA-like continuation coverage to your covered same-sex domestic partner and his or her covered children under circumstances in which your spouse or other dependent children would be entitled to elect COBRA. This continuation coverage will be subject to the same terms, conditions and limitations as COBRA continuation coverage that would be available to a covered spouse or other dependent children.

Without limiting the generality of the foregoing, you must notify the Plan Administrator within 60 days after the termination of your same-sex domestic partner relationship (including any termination of such relationship resulting from your same-sex domestic partner ceasing to satisfy the requirements for eligibility for coverage under the applicable benefit plans) or your same-sex domestic partner's children ceasing to be eligible under the terms of the applicable benefit plans. This notice must be provided to MySource for Human Resources. If notice is not provided within 60 days, there will no eligibility for continuation coverage.

Certificates of Group Health Coverage

If you or a covered dependent are no longer eligible for coverage under the Medical Plan, you will automatically receive a certification of group health plan coverage. A certification of group health plan coverage can be obtained from a MySource customer service associate any time during your coverage and during the 24-month period after your coverage under the Medical Plan ends.

Additional Information

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 necessary for the benefit plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information 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 Company, 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 or arbitration, that the covered person (or his or her legal representative) receives or is entitled to receive from any of the sources listed above. 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 minor 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 those benefit plans that make use of provider networks, provider lists may be obtained, without charge, at **www.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 or Columbia Energy Group. 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. 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.

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the benefit plans, including 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 Internal Revenue 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 Administration Department and third party administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrator 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 that are self-insured, the Committee has retained a Claims Administrator to provide claim payment and other administrative services to such plans. Even though an employee may receive a benefit check from a Claims Administrator, the Company, Columbia Energy Group or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although the Claims Administrator may have insurance coverage as part of its business, the Claims Administrator is not an insurer in relation to the self-insured plans. The self-insured plans are funded from the general assets of the Company or Columbia Energy Group 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.

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.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the benefit plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

Your Medical Plan Options

NiSource Inc. (the "Company") provides eligible employees and their dependents with the following medical coverage options administered by Anthem BlueCross/BlueShield:

- The Preferred Provider Organization (PPO), which uses the BlueCross/BlueShield Network;
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

The Medical Plan ("Plan") may also offer Health Maintenance Organizations ("HMO")—provided you live in an area where an HMO option is available. *If this option is available to you, you will be provided 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 Allowable Amount". Charges above the Maximum Allowable Amount are not paid by the Plan and are your responsibility. The Maximum Allowable Amount 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 Allowable 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 plans pay more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same deductible and coinsurance 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 your 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 **www.anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered through Express Scripts, Inc. ("Express Scripts"), which 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 coinsurance. These expenses are not subject to separate coinsurance 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 network, log on to **http://express-scripts.com/** or contact an Express Scripts customer service associate at the number on the back of your ID card to request assistance.

To find a provider who participates in the HDPPO network, log on to

www.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 **www.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 Services administered by Value Options. For additional details, see the section below entitled *"EAP/Work Life 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

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources 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"*.

In addition, notwithstanding the foregoing, in the event of a covered employee's death on or after January 1, 2004, coverage will continue for such employee's surviving dependents who are covered under the Plan on the date of that employee's death until the earlier of (i) the date the employee's surviving spouse or same-sex domestic partner dies, (ii) the last day of the month in which the employee's surviving spouse or same-sex domestic partner remarries or enters into a same-sex 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, and (v) with respect to any dependent, the date such dependent reaches age 65.

If a covered employee's surviving spouse or same-sex domestic partner remarries or enters into a domestic partnership or civil union with another person within the first 36 months after the employee's death, he or she may continue coverage for himself or herself and any qualified beneficiaries or covered dependents under COBRA or COBRA-like continuation coverage for the duration of the 36-month period. Also, if a covered employee's surviving spouse or same-sex domestic partner dies within the first 36 months after the employee's death, any surviving qualified beneficiaries or covered dependents may continue coverage for

themselves under COBRA or COBRA-like continuation coverage for the duration of the 36-month period. See the subsection below entitled "COBRA" for a discussion of COBRA or COBRA-like continuation coverage.

Also notwithstanding the foregoing, in the event of a covered employee's death before January 1, 2004, coverage may continue for such employee's dependents who are covered under the Plan on the date of that employee's death in accordance with a written plan or procedure, if any, applicable to such employee that was adopted by the Company and that was in effect as of December 31, 2003, as such plan or procedure was thereafter, or may hereafter, be modified by the Company.

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, coinsurance 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	$400 per covered member	$800 per covered member
Covered Member + Spouse	$400 per covered person	$800 per covered person
Covered Member + child(ren)	$400 per covered person, up to a total of $800	$800 per covered person, up to a total of $1,600
Covered Member + Family (spouse + children)	$400 per covered person, up to a total of $1,200	$800 per covered person, up to a total of $2,400
Office Visit Co-Pay/Coinsurance	$30	60% after deductible
Specialist Office Visit Co-Pay/Coinsurance	$35	60% after deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, deductibles, co-pays, balanced billed charges and expenses not covered under Plan)		
Covered Member	$1,000	$2,000
Covered Member + Spouse	$2,000	$4,000
Covered Member + Child(ren)	$2,000	$4,000
Covered Member + Family	$3,000	$6,000

****Please Note**: Where applicable, coverage categories include eligible same-sex domestic partner and eligible children of same-sex domestic partner.*

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 visits 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. *Please refer to the HMO SPD for further information regarding services provided under an HMO option*.

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	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)

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	**Plan Pays**
Outpatient Services		
Surgery	80% (after deductible)	60% (after deductible)
Dental/Oral Surgery	80% (after deductible)	60% (after deductible)
TMJ Appliances	80% (after deductible)	60% (after in-network deductible)
Second Surgical Opinions	100% (after $30 co-pay per office visit)	60% (after deductible)
Professional Services (Outpatient)		
	100%, (after $35 co-pay per office visit) (co-pay does not apply for allergy injections and serums)	60% (after deductible)
Emergency Care Services		
Accident (True Emergencies)	100% (after $100 co-pay)	100% (no co-pay or deductible)
Medical Emergency	80% (after deductible)	80% (after deductible)
Non-Medical Emergency	80% (after deductible)	80% (after deductible)
Urgent Care	100% (after $30 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	100% (after $35 co-pay per office visit)	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 $35 co-pay)	60% (after deductible)

TYPE OF SERVICE	PPO	
	IN-NETWORK	OUT-OF-NETWORK
	Plan Pays	**Plan Pays**
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $35 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	100% (no co-pay or 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 member generally must satisfy the "individual" covered member deductible requirement (currently $400 for in-network and $800 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered member 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, $800 for covered member + spouse or for covered member + child(ren), or $1,200 for covered member + family), additional covered members 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 $400 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 member must satisfy the $400 in-network deductible requirement before the "family" deductible requirement is met.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the deductibles, co-pays, coinsurance 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	$1,500	$2,500	$2,500
Covered Member + Spouse	$3,000	$3,000	$5,000	$5,000
Covered Member + Child(ren)	$3,000	$3,000	$5,000	$5,000
Covered Member + Family	$3,000	$3,000	$5,000	$5,000
Coinsurance				
	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)

FEATURE*	HDPPO 1		HDPPO 2	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
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	$4,500	$5,000	$7,500
Covered Member + Spouse	$6,000	$9,000	$10,000	$15,000
Covered Member + Child(ren)	$6,000	$9,000	$10,000	$15,000
Covered Member + Family	$6,000	$9,000	$10,000	$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	

**Please Note*:* *Where applicable, coverage categories include eligible same-sex domestic partner and eligible children of same-sex domestic partner.*

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options.

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**
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)	80% (after deductible)	80% (after deductible)	80% (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	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)	100% (no co-pay or deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)				
	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.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for medically necessary eligible expenses up to the maximum allowance. *For services covered under an HMO plan, please refer to the HMO SPD.*

The covered expenses under the medical 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 36 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. In some instances, the Plan may extend the limits based on medical necessity.

- 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);
  - 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 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 visits 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

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.

Notwithstanding the foregoing, regardless of whether you currently exhibit symptoms or have been diagnosed with a medical condition, the Plan pays benefits for one in-network mammography and one in-network colonoscopy per covered person per calendar year with no deductibles, co-payments or coinsurance.

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 recommend 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 coinsurance. Additional preventive health services furnished by out-of-network providers are subject to deductibles and coinsurance under the PPO option, but are covered by the Plan with no deductible, co-payments or coinsurance 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 coinsurance 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 coinsurance.

Recommended preventive health services fall under four broad categories, described below, that are specified in federal

regulations regarding coverage of preventive health services:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer;
  - Cervical cancer;
  - Colorectal cancer;
  - High Blood Pressure;
  - Type 2 Diabetes Mellitus;
  - Cholesterol;
  - Child and Adult Obesity;
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Women's contraceptives, sterilization procedures and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants;
  - Breastfeeding support, supplies and counseling. Benefits for breast pumps are limited to one per Plan Year; and
  - Gestational diabetes screening.

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins after the date the recommendations or guidelines are issued and will not remain covered services after the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services.

Please note that 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, coinsurance 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, coinsurance and/or deductible for the office visit.

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these services (or you may view the federal government's web sites, **http://www.healthcare.gov/center/regulations/prevention.html**; **http://www.ahrq.gov/clinic/uspstfix.htm**; or **http://www.cdc.gov/vaccines/recs/acip/**.)

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your

spouse, your same-sex domestic partner and your or your same-sex domestic partner's 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 or your same-sex domestic partner's female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call MySource for Human Resources at **1-888-640-3320**, or log on to the MySource for Human Resources website at **www.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 Allowable 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, call the Claims Administrator via MySource for Human Resources at **1-888-640-3320.**

Medical Expenses Not Covered

The medical expenses **not** covered include, but may not be limited to the following:

- Any condition, disease, defect, ailment, or injury that arises out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive benefits in whole or in part. It also applies whether or not you claim the benefits or compensation, and regardless of whether you recover benefits from any third party.
- Expenses for which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if you had applied for Part A and/or Part B (except as specified elsewhere under the Plan or as otherwise prohibited by federal law).
- Charges related to cosmetic surgery or related hospital admissions, unless made necessary:
  - By an injury;
  - For correction of congenital deformity when necessary to perform a normal body function;
  - For reconstructive surgery as necessary for the prompt treatment of a diseased condition.
- Any service or supply that is related to weight loss or the treatment of obesity (except for the surgical treatment of morbid obesity).
- Services associated with the treatment of infertility, including: artificial insemination; fertilization (such as in-vitro or GIFT); procedures and tests related to fertilization; and infertility drugs and related services that follow the diagnosis of infertility.
- Care received in an emergency room that is not considered emergency care (except as specified under the plan).
- Services or supplies that you receive at a health spa or similar type of facility.
- Self-help training and other forms of non-medical self care (except as provided under the plan).
- Radial keratotomy or keratomileusis, or excimer laser photo refractive keratectomy.
- Speech therapy, unless the therapy is expected to restore speech to a person who has lost speech function as a result of a disease or injury.
- Surgical-related expenses associated with Norplant and IUDs, elective abortions, or reverse sterilization.
- Custodial care, or for services received in an uncertified skilled nursing facility.
- Pre-admission testing if you decide to postpone your surgery.
- Dental implants.
- The Plan limits benefits for home health care services.
- Professional services when related to Depo-Provera injections or routine vision exams.
- Hospice care benefits for:
  - Home-delivered meals or homemaker services;
  - Respite care;
  - Traditional medical services to treat the terminal illness, disease, or condition;
  - Transportation, including – but not limited to – ambulance transportation; and
  - Care provided by a family member or friend.
- Human organ transplant benefits for the following:
  - Cardiac rehabilitation services provided more than three days after the recipient is discharged from the hospital;
  - Transportation by air ambulance for the donor or the recipient;
  - Travel time (and related expenses) required by a provider; or
  - Drugs that are experimental or investigational in nature.
- Dental appliances (except for intra-oral devices used in connection with the temporomandibular joint dysfunction

treatments) or the replacement of cataract lenses when a prescription change is not required.

- Orthotics when used for comfort only.
- Any cutting procedure in the mouth (except when performed in connection with the removal of non-impacted teeth, replacement of teeth, dentures or appliances, orthodontia or periodontia, alveoplasty, or the repair or preparation of the mouth to receive or maintain dentures).
- Charges that are not for the care or treatment of an injury or sickness, except as specifically provided for by the Plan.
- Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for oral surgery for repair of injury to natural teeth, or as provided herein.
- Charges for the non-surgical treatment of temporomandibular joint (TMJ) dysfunction except for the appliance.
- Charges for or related to some services, treatment, education testing or training related to learning disabilities or developmental delays.
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease.
- Charges related to services provided by the United States government, any state government, or any government outside the United States in which the participant or dependent is entitled to receive benefits. An exception to this exclusion applies for services provided by the United States government that can be billed to the Plan under COBRA.
- Charges that a covered person is not legally required to pay and charges that would not have been made if the Plan had not existed.
- Charges that exceed reasonable and customary charges or the Maximum Allowable Amount or are not medically necessary.
- Charges that are reimbursed, or that could be reimbursed, by any public program other than Medicaid, Medicare or TRICARE.
- Charges for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy.
- Charges for marriage, family, child, career, social adjustment, pastoral and financial counseling, except as provided by the EAP.
- Charges for acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery that is covered under the Plan.
- Charges for biofeedback services.
- Charges for examinations related to employment.
- Charge for examinations related to marriage.
- Charges for eye surgery performed primarily to correct refractive errors.
- Charges for experimental or investigational services. These include treatments, procedures, equipment, drugs, devices or supplies that in the judgment of the Claims Administrator are experimental or investigational for the diagnosis for which the person is being treated, and services not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator. They also include any services related to such treatments, procedures, equipment, drugs, devices or supplies, regardless of when incurred.
- Charges for chiropractic maintenance care.
- Charges for transportation to and from places of treatment and care, other than ambulance service when medically necessary.
- Charges related to any services or supplies for counseling related to sexual dysfunctions or inadequacies.
- Charges incurred prior to the effective date of coverage, or after the termination date of coverage.
- Charges for services rendered by a relative of the participant, or any other person who

resides in the same household as the participant.

- Charges incurred for the treatment of a sickness or injury as a result of any act of war, declared or undeclared.
- Charges incurred as a result of any act of rioting or civil disobedience.
- Court-ordered testing or care.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Missed or cancelled appointments.
- Mileage costs or travel expenses unless authorized by the Plan.
- Charges for custodial care, domiciliary or convalescent care, except as otherwise provided in the Plan.
- Charges for eyeglasses or contact lenses, except for the first pair of eyeglasses or contact lenses prescribed following cataract surgery.
- Charges for sex transformation surgery and related services, or the reversal thereof.
- Charges for reversal of sterilization.
- Charges for elective sterilization procedures for someone other than the participant or his or her spouse.
- Personal hygiene and convenience items.
- Charges for examinations relating to research screenings.
- Stand-by charges of a physician.

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 Express Scripts. 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 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 Express Scripts 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 Express Scripts otherwise.

The PPO coverage option also utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Express Scripts 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 Express Scripts toll-free at **1-855-846-6774**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a prescribed brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-

name drug), and if you request that the brand-name drug be dispensed, you will be responsible for the applicable co-pay plus the difference in cost between the brand-name drug and the generic substitute, unless your prescribing physician indicates that the brand-name drug is to be "dispensed as written."

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a 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.

If you fill your prescription at a nonparticipating pharmacy, the Plan pays the cost of the drug less the co-pay. The co-pay requirement applies to each original prescription or refill. If your physician authorizes a prescription refill, you must bring the prescription bottle or package to the participating pharmacy.

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 Express Scripts' 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 ***Express Scripts*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Prescription Order Form and your check to:
  Express Scripts, Inc.
  PO Box 66558
  St. Louis, MO 63166-6558
- 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 Express Scripts Network, contact Express Scripts at the number on the back of your ID card. Or you can log on to the Express Scripts website at **http://express-scripts.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	$15 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	$40 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	$90 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		
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 (coinsurance), or a set co-pay amount (not both). If your percentage of the cost results in an amount that is* ***less than* *the "minimum co-pay," you pay the minimum co-pay amount. If your percentage of the cost results in an amount that is* ***greater than*** *the "maximum co-pay," you pay up to the maximum co-pay amount. For the PPO Coverage Option, if you request that a brand-name drug be dispensed instead of its generic substitute, you may be responsible for paying the difference between the cost of the brand-name drug and the generic substitute, in addition to the applicable co-pay.*

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 coinsurance. These expenses are not subject to separate coinsurance 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.

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 coinsurance 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 **www.anthem.com**.

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 coinsurance.
- Mail the Prescription Order Form and your check to the address on the mail 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 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 **www.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**	
	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
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
	Retail Pharmacy		**Mail Order**	
Day Supply Limit	30-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		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.

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;
- 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;
- Vitamins (unless prescribed);
- 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 the following:
1) Mental Health and Substance Use Disorder Coverage, and 2) Employee Assistance Program (EAP)/Work Life Services benefits. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life Services benefits are administered by Value 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 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 the following 1) Mental Health and Substance Use Disorder Coverage, and 2) Employee Assistance Program (EAP)/Work Life Services benefits. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life Services benefits are administered through Value 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 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	OUT-OF-NETWORK
	Plan Pays	**Plan Pays***
Mental Health Inpatient	80% (after deductible)	60% (after deductible)
Mental Health Outpatient	100% (after $30 co-pay)	60% (after deductible)
Substance Use Disorder (Detox Inpatient)	80% (after deductible)	60% (after deductible)
Substance Use Disorder (Detox Outpatient)	100% (after $30 co-pay)	60% (after deductible)
Substance Use Disorder (Rehab Inpatient)	80% (after deductible)	60% (after deductible)
Substance Use Disorder (Rehab Outpatient)	100% (after $30 co-pay)	60% (after deductible)

**For out-of-network providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowable Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowable Amount. As a result you are responsible for any charges that exceed the Maximum Allowable 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.

MENTAL HEALTH AND SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK*
	Plan Pays (after deductible)	**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 Allowable Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowable Amount. As a result you are responsible for any charges that exceed the Maximum Allowable Amount.*

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 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 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 Services

Value Options offers you and your family information, resources and referrals on certain life issues that you may be facing. Issues such as:

- Finding child care
- Depression and anxiety
- Marital and family concerns
- Adopting a child
- Workplace concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and Financial Issues

Value Options' professional staff is available 24 hours a day, seven days a week at **1-800-946-5360**. Counselors will help you define your needs, provide counseling and support, and then carry out an extensive search for information and services compatible with your family's preferences and finances. Their service is free and confidential. If needed, the counselor will assist you in setting up an in-office visit with a Value Options EAP counselor in your area. You, a family member, or a household member may receive up to six free EAP sessions at no cost with the local EAP counselor.

You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If you need additional legal or financial assistance, your EAP counselor will refer you to an attorney or financial counselor in your community.

Counselors work hard to find resources that fit your budget requirements. If your Value Options EAP counselor provides a referral for services beyond the six free EAP visits, you are responsible for the cost of the care selected.

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 becomes entitled to Medicare due to end-stage renal disease, 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 payer of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

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 from the Claims Administrator by phone via MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website **www.mysourceforhr.com**.
- 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 MySource for Human Resources 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 – Medical and Dental Plans."*

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 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.

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;

Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

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:	Self-Funded. 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.
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) 647-5571**
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. 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 and Mental Health and Substance Use Disorders:	Anthem Insurance Companies, Inc. P.O. Box 37010 Louisville, KY 40233 **www.anthem.com** **1-800-228-2891**

Claims Administrator for EAP:	Value Options P.O. Box 1347 Latham, NY 12110-8847 **www.valueoptions.com** **1-800-946-5360**
Claims Administrator for Prescription Drug Service:	Express Scripts, Inc. (PPO) **http://express-scripts.com/** **1-855-846-6774** **1-800-899-2114** (TDD) *Mailing Address for Prescriptions (PPO)* Express Scripts, Inc. PO Box 66558 St. Louis, MO 63166-6558 *For Paper Claims (PPO)*: Express Scripts, Inc. ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872 *For Clinical Appeals (PPO):* Express Scripts, Inc. Attn: Pharmacy Appeals - KJJ Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439 Fax (877) 852-4070 The Anthem Prescription Drug Program (HDPPO 1 and HDPPO 2) P.O. Box 746000 Cincinnati, OH 45274-6000 **www.anthem.com** **1-800-228-2891** (mail order) **1-800-228-2891** (customer service)
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

Dental Plan

Your Dental Plan Options

NiSource Inc. (the "Company") offers the NiSource Dental Plan (the "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 MySource for Human Resource website at **www.mysourceforhr.com** or call the MySource 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

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources 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	
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.

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 MySource for Human Resources 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 MySource for Human Resources 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 June 15 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 MySource for Human Resources website **www.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 MySource for Human Resources 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 – Medical and Dental Plans."*

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 participating employers, through participant contributions and 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) 647-5571**
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 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 **www.cigna.com**
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue **Merrillville, Indiana 46410** **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

Vision Plan

Your Vision Plan Options

NiSource Inc. (the "Company") offers the NiSource Vision Plan (the "Plan") to eligible employees and their dependents with the following coverage options:

- Vision Plan option; and
- Basic Vision option.

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 doctors. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and/or eyewear from a VSP network doctor or a non-VSP provider. However, if you go to a VSP 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 Network Doctor** – 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 and eyewear from a VSP network provider, you are responsible for the amount in excess of the Plan's allowance, or 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 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 doctor who participates in the VSP Network, log on to the MySource for Human Resources website at **www.mysourceforhr.com** or call MySource 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

The employer and employee will contribute to the cost of the Plan in an amount determined on an annual basis or as otherwise required by a collective bargaining agreement. For further questions, please contact MySource for Human Resources at **1-888-640-3320** or log on to the MySource for Human Resources website at **www.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 NETWORK PROVIDER	NON-VSP PROVIDER
Exam			
	Once every calendar year	100%	Up to a $35 allowance
Lenses (per pair)			
Regular (single vision)	Once every calendar year	100%	Up to a $25 allowance
Lined Bifocal	Once every calendar year	100%	Up to a $40 allowance
Lined Trifocal	Once every calendar year	100%	Up to a $55 allowance
Lenticular	Once every calendar year	100%	Up to a $80 allowance
Frame			
	One every two consecutive calendar years	100%, Up to a $180 frame allowance	Up to a $45 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 $150 annual allowance	Up to a $105 allowance

If you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts and contact lens exam (fitting and evaluation). The contact lens exam is in addition to your vision exam to ensure proper fit of contacts.

Basic Vision Option

COVERED SERVICES	FREQUENCY	VSP NETWORK PROVIDER	NON-VSP PROVIDER
Exam			
	Once every calendar year	100%	Up to a $35 allowance

Vision Expenses Covered

The Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*."

The services and materials that the Plan covers include, but are not limited to, the following:

- One vision exam in every calendar year.
- Prescription eyeglass lenses, one pair in every calendar year, up to a specified lens allowance.
- Frame, one pair in every two consecutive calendar year period (up to the frame allowance).
- Contacts, one pair in every calendar year, up to a specified allowance. The allowance applies to the cost of your eye exam, contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of lenses.

Extra Discounts and Savings

When visiting a VSP network provider, you may receive:

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives;
- 20% off additional prescription glasses and sunglasses;
- 15% discount off the cost of an elective contact lens exam (fitting and evaluation);
- Polycarbonate lenses are covered in full for dependent children;
- 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. Visit the Claims Administrator's website at **www.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 MySource for Human Resources at **1-888-640-3320**.

Vision Expenses Not Covered

The Plan pays benefits for many vision care services and eyewear. However, some limits and exclusions do apply. If you want to know if a service or eyewear will be covered under the Plan, or if you have questions regarding your coverage, please ask your VSP provider or call the Claims Administrator.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a covered member selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the covered member will pay the additional costs for the options.

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Progressive multifocal lenses;
- UV (ultraviolet) protected lenses; or
- Certain limitations may apply on low vision care.

Not Covered

There are no benefits for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses;
- Two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under the Plan that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above Plan benefit allowances; and
- Services and/or eyewear not indicated as covered Plan benefits.

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 services (i.e., any amounts that exceed the Plan's specified allowances). You must incur eligible expenses no later than March 15 following the end of the Plan Year and submit them to the Health Care Flexible Spending Account no later than June 15 following the end of the Plan Year. Please see the "Flexible Benefits Plan" section of this Handbook for additional details about the Health Care Flexible Spending Account.

Coordination of Benefits (COB)

If you or your dependents have vision coverage under another plan, the primary plan is the one under which you are covered as an employee. Eligible dependent children receive primary coverage under their father's plan.

If your secondary plan pays the out-of-pocket expenses you incur under your primary plan, the following rules apply:

- The deductible (if any) under the secondary plan is waived;
- Payment under the secondary plan is made directly to you (according to the secondary plan's non-network provider schedule); and
- Any payment made toward a service or material that is covered under the secondary plan exhausts the secondary plan's coverage for that service for the entire benefit period.

If the primary plan already pays for a service or eyewear within the allowed period and you use a VSP network provider (in-network) under the secondary plan for that same service, the service is provided based on the secondary plan's preferred care provider schedule. In this case, deductible amounts (if any) toward that service apply under the secondary plan.

If you have primary coverage under another carrier, the Plan provides secondary coverage based on the coordination of benefits rules outlined in the "*Coordination of Benefits*" section of the **Benefits Program Overview**.

If you do not use the secondary plan to recover out-of-pocket expenses incurred under the primary plan, you can use the secondary plan for another claim (provided such services have been exhausted under the primary plan).

How to Access the Vision Benefits

Selecting a VSP Network Provider

- Log on to the MySource for Human Resources website at **www.mysourceforhr.com** to find the link to VSP's website that houses the most up-to-date list of VSP network providers; or call MySource for Human Resources at **1-888-640-3320** to locate a VSP network provider near you. Call the VSP 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 claim form. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete your portion of the claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the MySource for Human Resources website **www.mysourceforhr.com** and link to the Claims Administrator's website.
- Attach copies of your itemized bill and paid receipts to your claim form. These bill should include:
  - Name of patient;
  - Patient's relationship to you;
  - Patient's date of birth;
  - Name and Social Security number of employee;
  - Provider's bill; and
  - Copy of your itemized paid receipt (you can forward this to the Claims Administrator without a completed claim form as long as you include your name and social security number, the patient's name and relationship to you, and the patient's date of birth).

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Be sure to submit your completed claim to the Claims Administrator within six months 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 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 MySource for Human Resources 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 – 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 Inc. 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) 647-5571**
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 Providers):	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 **www.vsp.com**
Claims Administrator (Non-VSP Providers):	Vision Service Plan Insurance Company P.O. Box 997105 Sacramento, CA 95899-7105
Insurance Company:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670

Agent for Service of Legal Process: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, Indiana 46410
(219) 647-5571

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

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.

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 FSA 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 $2,500 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.

For reimbursement of health care expenses incurred by your same-sex domestic partner and his or her eligible children, see *"Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children"* below.

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 Internal Revenue 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

You can elect to participate in the FSA Plan provided you are classified as a regular full-time employee and your collective bargaining agreement provides for your eligibility in the FSA Plan.

For reimbursement under the Health Care FSA of health care expenses incurred by your same-sex domestic partner and his or her eligible children, see *"Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children"* below.

For purposes of the Dependent Care FSA, 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.

For reimbursement of expenses incurred by your same-sex domestic partner and his or her eligible children, see "Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children" below.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section of the FSA Plan, you can 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 "*Enrollment*" section and the "*Changing and Continuing Elections*" of the **Benefits Program Overview** for further details.

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 $2,500	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). For reimbursement of expenses incurred by your same-sex domestic partner and his or her eligible children, see "Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children" below.	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 Internal Revenue 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. • 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.	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.

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 Internal Revenue 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. 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 the Claims Administrator via MySource for Human Resources 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:

- Over the counter medications (other than insulin) obtained without a prescription;
- 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.

Reimbursement of Health Care Expenses Incurred by Same-Sex Domestic Partners and Their Children

If your same-sex domestic partner and his or her eligible children qualify as your tax dependents for health coverage purposes under the Internal Revenue Code, then you may pay for eligible health care expenses incurred by them with funds from your Health Care FSA. For a discussion of when your same-sex domestic partner or his or her eligible children may qualify as your tax dependents, see the subsection of the

Benefits Program Overview entitled "Tax Treatment."

If, at some point during the plan year, you terminate your same-sex domestic partner relationship, or your same-sex domestic partner or his or her children otherwise cease to meet eligibility requirements, then your same-sex domestic partner and/or his or her children will not be considered tax dependents for any part of the plan year. In that case, any reimbursement for health care expenses incurred by your same-sex domestic partner or his or her children prior to the termination of your relationship will have been inappropriate and may need to be repaid to your account or offset against future submitted claims. You should consult with a tax advisor if you have any questions about the tax implications of covering your same-sex domestic partner and his or her children under a Health Care FSA.

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. If you do not incur enough expenses to use all of the funds in your Health Care FSA by the end of the year, you may use an additional "grace period" (from January 1 until March 15) to incur expenses for the previous year's balance. You then have until June 15 to submit claims for expenses you incur between January 1 and December 31 plus the grace period.

Example: To show how you might use your Health Care FSA, assume that you elect to put $1,200 in your Health Care FSA for 2013. By December 31 you have incurred only $1,000 in eligible expenses. You have until March 15, 2014 (the end of the grace period) to incur additional expenses, and must submit all claims for your 2013 Health Care FSA by June 15, 2014.

Any health care expense incurred after March 15 will not be considered eligible for reimbursement from the prior year's funding. In addition, all expenses incurred between the previous January 1 and December 31 or during the grace period that follows must be submitted for payment no later than June 15.

Please note: *If you maintain a Health Care FSA during the current Plan Year and you want to participate in a high deductible health plan and contribute to a health savings account (HSA) during the next Plan Year, you must reduce the balance in your Health Care FSA (determined on a cash basis) to zero on or before December 31 of the current Plan Year. Pending claims, claims submitted, claims received, or claims under review that have not been paid as of December 31 are not taken into account in determining whether your Health Care FSA has a zero balance. If you fail to reduce the balance in your Health Care FSA to zero on or before December 31 of the current Plan Year, you may not contribute to an HSA until April 1 of the following year.*

Reimbursement Claims

A form can be obtained online via the MySource for Human Resources website **www.mysourceforhr.com**, or call the Claims Administrator via the MySource for Human Resources toll-free number **1-888-640-3320** to request a form.

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
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

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 not use your debit card to obtain reimbursement for over the counter medications, even if you have a prescription for such medications.

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 the Claims Administrator via MySource for Human Resources at **1-888-640-3320**.

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.

To obtain reimbursement for an expense, complete and submit a dependent care reimbursement form. A form can be obtained online via the MySource for Human Resources website **www.mysourceforhr.com**, or by calling the Claims Administrator via the MySource for Human Resources toll-free number **1-888-640-3320** to request a form.

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
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

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 June 15 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31), plus the grace period (January 1 through March 15 of the following year). 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 June 15 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 June 15 of the following calendar year to submit claims for expenses you incur during the Plan Year (January 1 through December 31). **The "grace period" does not apply to the Dependent Care FSA.** 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 June 15 will be forfeited.

Claim Determination and Appeal Process

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 for the Dependent Care FSA

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.

If, after completing all the steps of the claims procedure process, you decide to take legal action, you must do so within three years of the day the charge or claim is incurred.

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 Aon Hewitt. The participating employers have 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 Internal Revenue Code) for you, your spouse or dependents (as defined in Section 223 of the Internal Revenue 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, your Employer may make a monthly 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 each year is governed by federal law. Please call MySource for Human Resources 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 most retiree medical insurance or other qualified medical expenses on a tax-free basis, or you

can take a distribution, subject to income tax.

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

You can elect to contribute to an HSA if you are a regular full-time employee 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 Internal Revenue Code.

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

If you cover your same-sex domestic partner under HDPPO 1 or HDPPO 2, you are generally entitled to make contributions to your HSA up to the limit established for family coverage.

The special rule that limits the amount of HSA contributions by individuals who are married to each other when one spouse has family coverage does not apply to you and your same-sex domestic partner.

For information regarding reimbursement of qualified medical expenses for your same-sex domestic partner and his or her eligible children, see *"Reimbursement of HSA Qualified Medical Expenses for Same-Sex Domestic Partners and Their Children"* below.

Enrollment

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

Please note: *If you had a Health Care FSA (or any other health flexible spending account with a grace period feature) during the previous Plan Year and the balance in your account was not reduced to zero by December 31 of that Plan Year, you may not contribute to an HSA until April 1 of the following year.*

When Coverage Begins and Ends

Coverage Begins

You may enroll in the Health Savings Account (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 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.

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 Internal Revenue Code.

If you use your HSA for a non-medical or non-qualified medical expense, you will have to pay tax on the account distribution as well as a 20% penalty. If a distribution is made after age 65, after disability, or after death, the distribution will be subject to 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 ***www.irs.gov****.*

Reimbursement of HSA Qualified Medical Expenses for Same-Sex Domestic Partners and Their Children

If your same-sex domestic partner and his or her eligible children qualify as your tax dependents under the Internal Revenue Code, without taking into account their gross income, then you may pay for qualified medical expenses incurred by them with funds from your HSA. Note, however, that the extension of coverage to children until age 26, an important feature of health care reform, does not apply to HSAs; accordingly, reimbursement of such "adult children's" qualified medical expenses from your HSA on a tax-free basis is not permitted.

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, Aon Hewitt 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 Aon Hewitt. 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.

Please note: *You may not use your HSA debit card to pay for over-the-counter medications, even though you may have a prescription for such medications.*

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 MySource for Human Resources website **www.mysourceforhr.com** or call MySource for Human Resources 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.
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**
Fiduciary and Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**
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.
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 Aon Hewitt, 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:	Aon Hewitt 2300 Discovery Drive Orlando, FL 32826 **www.mysourceforhr.com**

Claims Administrator for Health Savings Accounts:	Aon Hewitt 2300 Discovery Drive Orlando, FL 32826 **www.mysourceforhr.com**
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

Long-Term Disability Plan

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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 MySource for Human Resources 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

You are eligible to participate in the Plan if you are a regular full-time employee of Columbia Energy Group who is covered by a collective bargaining agreement between Columbia Energy Group and a union and who regularly works 40 or more hours per week. Your eligibility for optional, contributory coverage may be subject to your satisfying other requirements established by Prudential. Refer to the Group Insurance Certificate for more details.

Information regarding eligibility can be accessed through the MySource website at **www.mysourceforhr.com** or by calling the MySource automated telephone system at **1-888-640-3320** to speak to a service representative.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section immediately 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.)

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 or as otherwise required by a collective bargaining agreement. *If you have questions regarding the amount of your required contributions, please contact MySource for Human Resources at **1-888-640-3320**.*

When Coverage Begins and Ends

Coverage Begins

Coverage under the Basic LTD Coverage Option of the Plan generally may become effective on (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) your first day of active employment for regular new hires, if you apply within 31 days of such date, (2) 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 (3) the date the Plan approves such enrollment due to a qualified life event.

Notwithstanding the foregoing, all employees must be in active employment in order for any coverage initially to become effective and for any subsequent Plan changes to take effect.

Coverage Ends

The coverage 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 Contract 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 or any applicable collective bargaining agreement;
- 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.

Highlights of the Long-Term Disability Plan Coverage

The following charts provide examples illustrating 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. The following are provided for illustrative purposes only and shall be construed in manner consistent with the terms of the Group Contract and your Group Insurance Certificate. In the event of a conflict between the following and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail.

If you are Disabled and Not Working

To show how your Monthly Benefit is calculated, let's assume that your monthly pre-disability earnings ("Monthly Earnings") equal $3,000, and that you qualify for a monthly Social Security Disability Benefit of $500. Here is how the Plan calculates your Monthly Benefit under both coverage options.

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

For example:

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Monthly Earnings*	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (Monthly Earnings times Percentage of Coverage) (A x B)	$1,500	$1,800
D	70% of your Monthly Earnings Less Deductible Sources of Income	$2,100 - 500 $1,600	$2,100 - 500 $1,600
E	**Monthly Benefit**** (Lesser of C or D)	**$1,500**	**$1,600**

**Your Monthly Earnings are indexed as provided in the Group Insurance Certificate.*

***The minimum monthly payment is the greater of (a) $100 or (b) 10% of your Gross Disability Payment. Prudential may apply this amount toward an outstanding overpayment. See "Taxability of Monthly Benefits" below for information regarding the taxability of monthly benefits you receive under the Plan.*

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 following examples show how your Monthly Benefit is calculated if you are working while you are disabled and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings.

First 12 months

To show how your Monthly Benefits are calculated during the first 12 months you are disabled and working and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings, assume that your Indexed Monthly Earnings are $3,000. Assume further that your Disability Earnings are $1,000, and that you are not receiving any other deductible sources of income. Here is how the Plan calculates your benefits under both coverage options:

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Indexed Monthly Earnings	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment (Monthly Earnings times Percentage of Coverage) (A x B)	$1,500	$1,800
D	Monthly Payment (Gross Disability Payment minus Deductible Sources of Income, if any)*	$1,500 - 0 $1,500	$1,800 - 0 $1,800

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
E	Add Disability Earnings and Gross Disability Payment to determine if the sum exceeds Indexed Monthly Earnings	$1,000 +1,500 $2,500 (does not exceed $3,000)	$1,000 +1,800 $2,800 (does not exceed $3,000)
F	Subtract the amount that Disability Earnings plus the Gross Disability Payment exceeds Monthly Earnings (E - A, if > 0) from the Monthly Payment in D to determine the Monthly Benefit	$1,500 - 0 $1,500	$1,800 - 0 $1,800
G	**Monthly Benefit****	**$1,500**	**$1,800**

**Deductible sources of income are subtracted only if the Percentage of Coverage is 70%*

***See "Taxability of Monthly Benefits" below for information regarding the taxability of monthly benefits you receive under the Plan.*

After First 12 months

To show how your Monthly Benefit is calculated after the first 12 months you are disabled and working and your Disability Earnings are equal to or greater than 20% but no more than 80% of your Indexed Monthly Earnings, assume that your Indexed Monthly Earnings are $3,000 and your Disability Earnings are $2,000. Assume also that you do not qualify for Social Security Disability Benefits. Here is how the Plan calculates your Monthly Benefit under both coverage options.

	COMPONENT	BASIC LTD COVERAGE OPTION	SUPPLEMENTAL LTD COVERAGE OPTION
A	Indexed Monthly Earnings	$3,000	$3,000
B	Percentage of Coverage	50%	60%
C	Gross Disability Payment(*A x B*)	$1,500	$1,800
D	Your Indexed Monthly Earnings less your Disability Earnings	$3,000 - 2,000 $1,000	$3,000 - 2,000 $1,000
E	Lost earnings percentage calculation	$1,000 = .33 $3,000	$1,000 = .33 $3,000
F	Gross Disability Payment less any Deductible Sources of Income*	$1,500 - 0 $1,500	$1,800 - 0 $1,800
G	**Monthly Benefit *(E x F)*****	**33% x $1,500 = $500**	**33% x $1,800 = $600**

**Deductible sources of income are subtracted only if the Percentage of Coverage is 70%*

***See "Taxability of Monthly Benefits" below for information regarding the taxability of monthly benefits you receive under the Plan.*

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.

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 who are on layoff or leave of absence or 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; (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, or (iii) any loss of time disability payments under the United States Social Security Act or any similar plan or act, (b) any retirement payments you receive under the United States Social Security Act or any similar plan or act, or (c) amounts you receive as disability payments, that you voluntarily elect to receive as retirement or early retirement payments, or that you receive as retirement payments when you reach normal retirement age, under your Employer's retirement plan. 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 will not be included as disability earnings since 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 for 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 includes 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 NiSource 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 Internal Revenue 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

Your maximum period of payment 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 MySource for Human Resources 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.

For purposes of this Plan, the term "spouse" includes your same-sex domestic partner, as that term is defined in the **Benefits Program Overview.**

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 MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website at **www.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 and Life and AD&D Plans."*

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 MySource for Human Resources.

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
You cannot continue to make contributions to the Health 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. If you return to work, your original contribution election is amortized over the remaining pay periods for the calendar year.

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
While you are receiving Plan benefits, you are not entitled to receive any employer contributions to an HSA, nor may you contribute to an HSA by means of payroll deduction.

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 **www.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) 647-5571**
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 51 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, PA 19176
Agent for Service of Legal Process:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

Service of legal process may be made upon the Plan Administrator.

The Group Contract underwritten by The Prudential Life 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 MySource automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

The Prudential Life 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 Insurance Plan

Your Life Insurance and AD&D Options

NiSource Inc. (the "Company") offers the NiSource Life Insurance Plan (the "Plan") to eligible employees with the following coverage options (each a "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

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 ("Minnesota Life"), who is the 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 MySource for Human Resources 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

Employees

You are eligible to participate in the Plan if you (i) are a regular full-time employee of Columbia Energy Group who is covered by a collective bargaining agreement between Columbia Energy Group and a union, (ii) regularly work 40 or more hours per week or at least the number of hours per week set forth in your collective bargaining agreement as being the minimum necessary to be classified as a full-time employee entitled to benefits under the Plan, 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 Minnesota Life.

See the individual benefit plan sections below and refer to the Group Insurance Certificate for further details.

Eligible Dependents

If you are eligible to participate in the Plan, you may obtain certain coverage for your "eligible dependents." Your "eligible dependents" are:

- Your lawful spouse; and
- Your unmarried children from live birth to the end of the month in which the unmarried child attains age 26; and

For purposes of this Plan, the term "spouse" or "lawful spouse" includes your same-sex domestic partner, as that term is defined in the **Benefits Program Overview**.

Your "children" include: (1) your or your same-sex domestic partner's natural children, legally adopted children and children placed

with you or your same-sex domestic partner for adoption prior to legal adoption; and (2) each of your or your same-sex domestic partner's stepchildren, foster children, children subject to legal guardianship, grandchildren, and other children who are blood relatives who depend on you or your same-sex domestic partner for more than fifty percent of their support and maintenance. A child placed with you or your same-sex domestic partner 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 or your or your same-sex domestic partner, as the case may be.

Notwithstanding the foregoing, your or your same-sex domestic partner's 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 Note: It is your responsibility to advise MySource when a person is no longer eligible for coverage as an eligible dependent under the Plan. Any amounts paid on behalf of a person who is no longer an eligible dependent will be required to be repaid to the Plan.

*Information regarding eligibility can be accessed through the MySource website at **www.mysourceforhr.com** or by calling the MySource automated telephone system at **1-888-640-3320** to speak to a service representative.*

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section above, you will be automatically enrolled in the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option. If you desire coverage as a newly eligible employee, you must enroll in the Optional Employee Term Life Coverage Option, the Dependents Term Life Coverage Option, the Supplemental Employee AD&D Coverage Option and the Dependents AD&D Coverage Option (collectively the "Optional Coverages") within 31 days of your date of hire or the date you become newly eligible. If you do not enroll in an Optional Coverage 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 Minnesota Life. *You may obtain enrollment forms by contacting MySource for Human Resources at **1-888-640-3320***

In general, once you enroll in (or decline) any of the Optional Coverages, 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. If any change in coverage is subject to evidence of insurability, Minnesota Life must decide that such evidence is satisfactory. (Please see the "*Enrollment*" and the "*Changing and*

Continuing Elections" section of the **Benefits Program Overview** for further details.) *To obtain the necessary forms for enrolling in, or changing, your Optional Coverages, please contact MySource for Human Resources at **1-888-640-3320**.*

Contributions

Premium contributions are not required for the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option. If you elect any of the Optional Coverages, you will pay for the cost of such coverage. *If you have questions regarding the amount of your required contributions, please contact MySource for Human Resources at **1-888-640-3320**.*

When Coverage Begins and Ends

Coverage Begins

Provided you have satisfied the eligibility requirements described above, coverage under the Basic Employee Term Life Coverage Option and the Basic Employee AD&D Coverage Option of the 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 Coverages 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 Optional Employee Term Life Coverage, 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 Certificate, 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 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 Dependents Term Life Coverage, you are covered under Employee Term Life Coverage, and for Dependents AD&D Coverage, you are covered under Supplemental Employee AD&D Coverage), (4) for Dependents Term Life Coverage, 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 Optional Employee Term Life Coverage. 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 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 Minnesota Life, 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 Insurance or Dependents Insurance under a Coverage Option will end when the first of these occurs:

- The date as of which the Plan is terminated;
- The date the Group Contract is canceled, or with respect to a particular Coverage Option, the date a Coverage Option is terminated;
- The date that the 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 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 Insurance will not cause your Employee Insurance to end;
- For Dependents Term Life Coverage, the date your Employee Term Life Coverage ends;
- For Dependents AD&D Coverage, the date your Supplemental Employee AD&D Coverage ends;
- For Dependents 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 Employee Optional Coverage, the last day for which premium contributions have been made following your written request to end any Employee Optional Coverage.
- For Dependents Insurance, the last day for which premium contributions have been made following your written request to end Dependents Insurance for an "eligible dependent"

You must notify the Claims Administrator when a dependent is no longer eligible for coverage under the Plan so that premiums may be discontinued.

If your Employee Insurance coverage 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 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.

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 Coverage Option. You can obtain a beneficiary form by calling MySource at **1-888-640-3320**. Minnesota Life has prepared information about the modes of settlement that are available. For further information, contact MySource at **1-888-640-3320**.

The Group Insurance Certificate also contains rules regarding the assignment of your insurance under a Coverage Option. Refer to the Group Insurance Certificate for the terms and conditions under which such assignments may be made.

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. 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 "Terminal Illness Proceeds" paid under the Option to Accelerate Payment of Death Benefits.

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 insurance is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit is $1,500,000 minus the amount of your insurance under the Basic Employee Term Life Coverage Option. Amounts otherwise payable as benefits will be reduced by the amount of any "Terminal Illness Proceeds" 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 Minnesota Life 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 Optional Employee Term Life Coverage 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 Optional Employee Term Life Coverage 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 Optional Employee Term Life Coverage 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 Optional Employee Term Life Coverage, 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 Term Life Coverage 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 Minnesota Life.

Any new enrollment or requested increase in coverage that is subject to evidence of insurability will become effective when Minnesota Life 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 Minnesota Life decides the evidence is satisfactory and you are actively at work.

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 Death Benefit paid to you in one full sum when Minnesota Life receives proof that you have a Terminal Condition.

Benefits otherwise payable under the Employee Term Life Insurance upon your death and any amount that could otherwise have been converted to an individual contract will be reduced by the Accelerated Death Benefit.

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) Your Employee Term Life Insurance must not be assigned; (4) You must not have designated an irrevocable beneficiary for your Employee Term Life Insurance ; (5) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this option; and (6) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this option.

You have a “Terminal Condition” if you have a condition caused by sickness or accident which directly results in a life expectancy of twelve months or less. “Accelerated Death

Benefit" means the amount of your Employee Term Life Insurance that Minnesota Life will pay if you are eligible under this option. The Accelerated Death Benefit is equal to 100% of the amount in force on your life on the date Minnesota Life receives the proof that you have a Terminal Condition, but not more than $1,000,000. The minimum death benefit eligible for an Accelerated Death Benefit is $10,000. Minnesota Life 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.

If you elect to accelerate your death benefit and the termination of your coverage causes an eligible dependent to lose 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 death benefit payable under the Accelerated Death Benefit Option, your Employee Term Life Insurance coverage (reduced by the amount of the Accelerated Death Benefit) will continue after your election of the Accelerated Death Benefit Option and your premiums will be reduced accordingly. The amount of the Accelerated Death 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 made under this option 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; or
- If your spouse previously did not meet a requirement for evidence of insurability under any Minnesota Life group contract for the participating employer.

Option 3 spousal coverage will become effective on the first day of the month following the date Minnesota Life decides the evidence is satisfactory. 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.

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 Minnesota Life'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 Minnesota Life receives written proof as described above.

Death Benefits under the Employee Term Life Coverage are payable according to Minnesota Life's beneficiary and mode of settlement rules. Death benefits under the Dependents Term Life Coverage 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 Dependents Term Life Coverage 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 Minnesota Life 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 Minnesota Life 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 Basic and Supplemental Employee and Dependents AD&D Coverage 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 Minnesota Life 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.

Portability of Life and AD&D Coverage

If coverage under any of the Coverage Options ceases, you may have the right to apply for coverage for yourself or for your "eligible dependent," as the case may be, under a Portability Plan maintained by Minnesota Life. 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.

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 Coverage and Dependents Term Life Coverage, except that you or your "eligible dependent," as the case may be, may convert the amount of insurance under the Employee Term Life Coverage or Dependents Term Life Coverage 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 Minnesota Life 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 or same-sex domestic partner. 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 or same-sex domestic partner.

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 Minnesota Life. 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 or same-sex domestic partner 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 same-sex domestic partner 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, Dependent Child Life be converted or ported?	Yes	Yes
Can AD&D be converted or ported?	No	Yes
Can a retiree convert or port coverages?	Yes	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. Minnesota Life will bill the participant directly. For AD&D coverage, 31 days after your coverage termination.
Minnesota Life Contacts	Minnesota Life Insurance Company 400 North Robert Street St. Paul, MN 55101	Minnesota Life Insurance Company 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, Minnesota Life 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 Coverage 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 Minnesota Life. Claim forms can be obtained from Minnesota Life by phone via MySource for Human Resources at **1-888-640-3320**, or online via the MySource for Human Resources website at **www.mysourceforhr.com**. If you do not receive the form from Minnesota Life within 15 days of your request, send Minnesota Life 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 – Long-Term Disability and Life and AD&D Plans."*

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) 647-5571**
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 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company 400 North Robert Street St. Paul, MN 55101
Agent for Service of Legal Process:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 **(219) 647-5571**

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. 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 MySource automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Minnesota Life 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.

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CEG (Actives) Premiums & Contributions

		2016 Annual Contribution				2015 Annual Contribution				2014 Annual Contribution			
SI/FI	**Option Description**	**EE**	**SP**	**CH**	**FM**	**EE**	**SP**	**CH**	**FM**	**EE**	**SP**	**CH**	**FM**
SI	PPO	2,475.14	4,950.25	4,826.48	8,044.14	2,209.08	4,418.13	4,307.66	7,179.45	2,100.92	4,201.84	4,096.78	6,827.98
SI	High Deductible PPO 1	768.00	1,356.00	1,320.00	2,208.00	672.00	1,140.00	1,140.00	1,620.00	600.00	900.00	900.00	1,200.00
SI	High Deductible PPO 2	120.00	180.00	180.00	240.00	60.00	120.00	120.00	180.00	60.00	120.00	120.00	180.00
FI	Health America - Pittsburgh	1,852.86	3,705.72	3,613.11	6,023.07	1,747.98	3,495.96	3,408.60	5,682.15	1,642.86	3,285.69	3,203.61	5,340.39
FI	HealthSpan	1,842.30	3,684.57	3,592.47	5,987.49	1,682.46	3,364.89	3,280.77	5,468.01	1,599.15	3,198.27	3,118.32	5,197.26
FI	Keystone Health Plan - Central	n/a	n/a	n/a	n/a	3,952.44	7,904.98	7,707.43	12,845.72	2,244.12	4,488.12	4,375.97	7,293.29
FI	Optimum Choice	n/a	n/a	n/a	n/a	5,836.92	11,673.22	11,381.11	18,968.60	3,978.72	7,956.84	7,757.69	12,929.57
FI	Tufts HMO	2,155.95	4,311.87	4,204.11	7,006.80	1,907.91	3,815.82	3,720.45	6,200.70	1,799.91	3,599.82	3,509.85	5,849.73

		2016 Annual Premium				2015 Annual Premium				2014 Annual Premium			
SI/FI	**Option Description**	**EE**	**SP**	**CH**	**FM**	**EE**	**SP**	**CH**	**FM**	**EE**	**SP**	**CH**	**FM**
SI	PPO	9,900.56	19,800.99	19,305.93	32,176.56	8,836.32	17,672.51	17,230.63	28,717.81	8,403.68	16,807.36	16,387.13	27,311.93
SI	High Deductible PPO 1	4,525.94	9,051.73	8,825.55	14,709.12	3,952.41	7,904.82	7,707.22	12,845.33	3,574.09	7,148.19	6,969.43	11,615.81
SI	High Deductible PPO 2	4,007.63	8,015.41	7,815.08	13,025.13	3,356.04	6,712.22	6,544.48	10,907.34	3,034.78	6,069.69	5,917.99	9,863.27
FI	Health America - Pittsburgh	7,411.44	14,822.88	14,452.44	24,092.28	6,991.92	13,983.84	13,634.40	22,728.60	6,571.44	13,142.76	12,814.44	21,361.56
FI	Kaiser Permanente	7,369.20	14,738.28	14,369.88	23,949.96	6,729.84	13,459.56	13,123.08	21,872.04	6,396.60	12,793.08	12,473.28	20,789.04
FI	Keystone Health Plan - Central	n/a	n/a	n/a	n/a	10,579.68	21,159.36	20,630.40	34,384.08	8,546.88	17,093.64	16,666.32	27,777.24
FI	Optimum Choice	n/a	n/a	n/a	n/a	12,464.16	24,927.60	24,304.08	40,506.96	10,281.48	20,562.36	20,048.04	33,413.52
FI	Tufts HMO	8,623.80	17,247.48	16,816.44	28,027.20	7,631.64	15,263.28	14,881.80	24,802.80	7,199.64	14,399.28	14,039.40	23,398.92

Notes

- Contributions shown are for Columbia Energy Group Active full-time employees
- HD PPO 1 premiums do not include the seed amounts
  - 2014: $600
  - 2015 & 2016: $800
- HD PPO 2 premiums do not include the seed amounts
  - 2014-2016: $300
- Keystone Health and Optimum Health no longer offered in 2016

SUMMARY PLAN DESCRIPTION FOR THE

Columbia Energy Group Pension Plan

A DESCRIPTION OF YOUR RETIREMENT PENSION BENEFITS

For Employees in the AB II Benefit

April 2013

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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, Columbia Energy Group, 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 Columbia Energy Group 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 Resources 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 greater of the 30-year Treasury Securities, 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, and effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay). 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 on or before January 1, 2010; (2) a non-union "non-exempt employee" (as classified by the Company) whose most recent hire date is on or before January 1, 2013; or (3) a union employee whose most recent hire date is on or before January 1, 2013. 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 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 meet the eligibility requirements, your participation starts on your first day of work with the Company. Once you start to participate in the Plan, you will 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 as an "exempt employee" on or after January 1, 2010, as a "non-exempt employee" on or after January 1, 2013, or as a union employee on or after January 1, 2013, you are not a Pension Eligible Employee and you are no longer eligible to earn additional benefits under the Plan.

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 as an ineligible employee (*i.e.*, you are no longer a Pension Eligible Employee), you no longer earn Point Service under the Plan. 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 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 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, 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 Service under the Plan. 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 and Point Service will depend on the following: (1) the length of your Break in Service; (2) whether you were vested in your pension benefit prior to the Break in Service; and (3) whether you received a distribution of your benefit under the Plan. Note again that if you are not a Pension Eligible Employee at your rehire, these Break in Service provisions will not apply for purposes of accruing any future Point 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, the Plan will consider your period of absence as part of your Vesting Service and Point Service under the Plan. However, as noted below, if you receive a distribution of your benefit, then your Point Service will start at zero upon your return to employment.

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 Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. If you are re-employed, the period of your absence will not count as part of your 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 Service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you are vested when you terminate employment and you are later re-employed after a Break in Service of 5 or more years, the Service you earned before your termination will be added to the Service you earn after you return to work for all purposes under the Plan. However, the Company does not count the period of your absence as part of your Service.

If You Received a Distribution

If you experience a Break in Service *and* receive or begin to receive a distribution of your vested benefit under the Plan before your return to work, you will receive credit for your Service prior to the break for purposes of counting Vesting Service only. For purposes of earning pay credits and interest credits (explained later in the "How the Plan Works" section), if you were a Pension Eligible Employee at the time of your rehire, then you were treated as a new participant (*i.e.*, your Point Service started at zero upon your return to employment).

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). 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, 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 Final Average Pay Benefit ("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.

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 is a technical term under the Plan referring 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) (included effective September 1, 2009), plus
- Any amounts attributable to "banked" vacation and paid to you under the NiSource Vacation Policy.

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.

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-Based 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 $255,000 for 2013 (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 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 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 2013, the SSWB is $113,700. 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 $56,850 in 2013 ($113,700 divided by two).*

Example

Assume that on December 31, 2013, 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 2013 (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 $60,000 for 2013, he would receive a Basic Pay Credit of $2,400 (4% of $60,000), plus an Excess Pay Credit of $31.50 (1% of $3,150, 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 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, 2013, 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 for September 2012 or 4%). On December 31, 2013, 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:

- **Your 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 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 $60,000 and have completed 17 years of Point Service at the end of 2013, your 2013 Pay Credit would be calculated as follows:

Basic Pay Credit

Your 2013 Eligible Pay	$60,000
Your Basic Pay Credit % (49 + 17 = 66 points = 5%)	x 5%
Your Basic Pay Credit amount on December 31, 2013	**$3,000**

Excess Pay Credit

Your 2013 Eligible Pay over ½ SSWB ($60,000 – $56,850)	$3,150
Your Excess Pay Credit %	x 1%
Your Excess Pay Credit amount on December 31, 2013	**$31.50**

Your total Pay Credit on December 31, 2013 is the sum of $3,000 + $31.50 or a total of $3,031.50 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, 2013 was $50,000, then you received an Interest Credit effective as of December 31, 2013 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%)	+ $3,000
December 31 Excess Pay Credit (1%)	+ $31.50
December 31 Account Balance	**$55,031.50**

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 MySource for Human Resources 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 (to convert your Account to an annual benefit) at that time is 11, you would receive either a lump sum of $200,000 (minus applicable withholding taxes) or a monthly benefit for life of approximately $1,515, as follows:

CALCULATING ANNUITY EXAMPLE	
Account Balance:	$200,000
Annuity Factor:	÷ 11
Annual Benefit:	$ 18,182
	÷ 12
Monthly Benefit:	$ 1,515

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**"); 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 be unreduced.

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.

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:

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

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 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 your benefit is $5,000 or less, you will automatically be paid a single lump sum as soon as practicable after your termination. Alternatively, if your vested benefit amount is more than $5,000, 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 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 MySource for Human Resources on or before November 30 requesting commencement of pension distribution.

Applying for Benefits

If you are retiring, you must call MySource for Human Resources 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 only with your spouse's notarized 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 $5,000 or less. Again, if your vested Plan benefit is $5,000 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. Note that if you do not make a payment election (direct payment vs. rollover) and your benefit is greater than $1,000 but less than or equal to $5,000, then the Plan Administrator will roll over your benefit to an IRA designated by the Plan Administrator. If your benefit is $1,000 or less when you leave the Company, and you do not elect whether to receive this benefit directly or 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 $5,000, 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 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 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 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 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. This option is available effective January 1, 2008. If you are married, you may not name a non-spouse beneficiary to receive this form of payment without your spouse's notarized 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 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 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 3.77% 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	$996.36	$0.00
50% Pop-Up Annuity (unreduced for pop-up feature with spouse as beneficiary)	$952.52	$476.26
33-1/3 % Annuity	$967.46	$322.16
66-2/3% Annuity	$939.56	$626.69
75% Annuity	$932.59	$699.44
100% Annuity	$912.66	$912.66
5 Year Certain and Life Annuity	$992.37	$992.37 (paid until the end of 5-year period if participant dies before such date)
10 Year Certain and Life Annuity	$981.71	$981.71 (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:

- 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 (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 should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. The Social Security office can advise you on the documents you will need in order to apply for this benefit.

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 MySource for Human Resources at **1-888-640-3320** or **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 MySource for Human Resources.

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 MySource for Human Resources 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 Plan Administrator 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 MySource for Human Resource 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 MySource for Human Resources at **1-888-640-3320** or **www.mysourceforhr.com**. You or your spouse should submit a draft version of a domestic relations order to the Plan Administrator 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 MySource for Human Resources at **1-888-640-3320**. When the Plan Administrator 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 were) 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 Plan Administrator 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 provides otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources 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 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 provides otherwise, your benefit will be determined as set forth below. See the NiSource Human Resources 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. If the affiliate’s plan provides for your participation in a FAP Benefit option, you shall begin participation in such option with zero credited service.</td></tr>
<tr><td>Non-union
(exempt or non-exempt)</td><td>Union</td></tr>
<tr><td>Union</td><td>Union</td></tr>
</table>

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:*
Union	NiSource Corporate Services	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)	NiSource Corporate Services	

*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 exempt Pension Eligible

Employee became an AB II Participant effective January 1, 2012 and any Disabled non-exempt or union Pension Eligible Employee became an AB II Participant effective January 1, 2013. 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 to 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 <u>and</u> 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 MySource for Human Resources 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 MySource for Human Resources (**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;
- References 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 MySource for Human Resources 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 Columbia Energy Group.

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
1-219-647-5571

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for Columbia Energy Group is 13-1594808.

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 $165,000

(indexed for 2013), 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.
Senior Vice President of Human Resources
801 East 86th Avenue
Merrillville, IN 46410

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

State Law

Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law.

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.

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Summary Plan Description and Prospectus

for the

NiSource Inc. Retirement Savings Plan

Specifically designated portions of this document constitute part of a prospectus covering securities that have been registered under the Securities Act of 1933. This document covers NiSource Inc. common stock offered through the NiSource Inc. Retirement Savings Plan. These securities have not been approved or disapproved by the Securities Exchange Commission, nor has the Commission passed upon the adequacy of this Summary Plan Description and Prospectus. Any contrary representation is a criminal offense.

April 2016

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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?" No doubt you will be relying on (1) your retirement benefit from the **NiSource Inc. Retirement Savings Plan** (the "**Plan**")[1],* (2) a retirement benefit from Social Security and (3) your personal savings. In addition, if you are (or were) eligible to participate in one of the pension plans sponsored by NiSource Inc. or an affiliate, you will also rely on any retirement benefit that you receive under your pension plan.

NiSource Inc., Columbia Energy Group, Bay State Gas Company ("Bay State"), Northern Indiana Public Service Company ("NIPSCO") [2] or any affiliated companies that have adopted the Plan (collectively or individually, as the context requires, referred to as the "**Company**"), offer the Plan in order to help its Eligible Employees to financially prepare for their retirement years. Accordingly, the Plan is designed to provide you with retirement benefits when you terminate employment with the Company.

Why save through the Plan?

- *Automatic Payroll Deductions:* Often, the most difficult part about saving is doing it regularly and consistently. With the Plan, you decide how much to contribute. You can contribute from 1% to 50% of your eligible compensation on a pre-tax or Roth basis and up to 25% on an after-tax basis (subject to IRS limitation). That amount is *automatically* deducted from your paycheck. In addition, you can make "catch-up" contributions commencing in the year you turn age 50. You are always 100% vested in your own contributions to your account.

- *Company Matching Contributions:* The Company matches a portion of your contributions every payroll period (catch-up contributions are not matched). You are always 100% vested in your Company matching contributions.

- *Tax Advantages:* The Plan offers the option of saving on a before-tax basis -- meaning your contributions are deducted from your pay before most taxes have been withheld, effectively lowering your taxes today. In addition, the investment earnings of your Plan account are not taxed until you withdraw them from your account.

- *A Variety of Investments:* Regardless of your goals or investment preferences, the funds offered through the Plan fit a wide range of "comfort" levels (*i.e.,* different investment risk levels). You decide how your contributions are invested among a variety of investment options.

- *Flexibility:* With the Plan, you are never locked into just one way of saving or investing. Recognizing that your needs change over time, the Plan allows you to frequently change your investment elections and contribution amounts.

- *Access Before Retirement:* Although the goal of the Plan is to help you save for retirement through long-term investment, there may be times before retirement when you need your money. Depending on your circumstances, you may be able to borrow from part of your account for those needs. You may request a withdrawal from your rollover or after-tax contributions at any time, which may be subject to tax consequences.

- *Benefit Payment Options*: If you leave the Company, you generally can elect the following benefit payment options: defer payment (until no later than age 70½), take a lump sum distribution, receive installment payments, or roll over your account. If you die, your designated beneficiary or beneficiaries will be eligible to receive your Plan account.

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[1] Prior to December 31, 2008, rather than the NiSource Inc. Retirement Savings Plan, certain Eligible Employees participated in the Northern Indiana Public Service Company Bargaining Unit Tax Deferred Savings Plan or the Bay State Gas Company Savings Plan for Operating Employees. On and after December 31, 2008, all Eligible Employees participate in the Plan, which includes these former plans (merged into the Plan on that date).

[2] Effective as of July 1, 2011, Kokomo Gas and Fuel Company ("Kokomo") and Northern Indiana Fuel & Light Company ("NIFL") merged with and into NIPSCO. If you were an employee of Kokomo or NIFL, references to NIPSCO in this Summary or its schedules will generally apply to you, unless otherwise noted.

- *Benefit Information Access*: You can call Fidelity Benefits Service Center at **1-800-305-401k** (4015) for your Account information, 24 hours a day, seven days a week. You can also visit NetBenefits at **www.401k.com** to view your account online.

Plan Overview

The Plan is a "**401(k)**" plan. The term "401(k)" refers to a specific section of the Internal Revenue Code that authorizes this type of plan. This term describes the feature of the Plan that permits you to elect to have the Company contribute a portion of your pay from the Company to the Plan. These payments to your Account are called "**Elective Deferral Contributions**" or, if applicable, "**Catch-Up Contributions**." The Plan also allows you to make "**After-Tax Contributions**" to your Account. The Company makes "**Matching Contributions**" to encourage employees to participate in the 401(k) savings program and may make certain other contributions as described on the attached applicable Schedule (collectively, "**Company Contributions**"). The Plan also permits you to make "**Rollover Contributions**" to the Plan from another qualified retirement plan. (See "Rollover Contributions" section).

As a participant in the Plan, you will have a separate account (an "**Account**") established which will hold your share of contributions to the Plan. Under the Plan, you will not receive a fixed dollar amount of retirement benefits. Instead, your actual distribution of funds will depend on the amount of your Account at the time you receive your benefit. At your retirement or termination of your employment, you are entitled to receive a distribution equal to the value of your Account. The balance of your Account will reflect the amount of the contributions that you made to your Account and contributions made by the Company, plus the return on your investments for the period of time you participated in the Plan.

The NiSource Benefits Committee (the "**Committee**") serves as administrator for the Plan (the **"Plan Administrator"**). The Plan Administrator utilizes Fidelity Investments ("**Fidelity**") to carry out a number of administrative tasks for the Plan. In addition, the Plan Administrator in its discretion may also delegate other administrative tasks to the Company's Human Resource Department or other designated individuals. See "Administrative Information" found later in this Summary. A trust fund ("**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. The Committee oversees all investment options offered under the Plan. You are permitted to direct the investment of the money in your Account.

About This Plan Summary

This handbook (including the attached applicable Schedule of Benefit Information, the "**Schedule**") 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"). It is not intended to be a complete description of the Plan, but merely a brief summary of Plan highlights. This Summary is based on official documents that may include policies, contracts, plans and trust agreements. Note that this Summary is not an invitation to participate in the Plan nor is it an offer to buy or sell securities. Your rights and benefits under the Plan are determined by the actual provisions of the Plan. Although every effort has been made to ensure that this explanation of the Plan is accurate, the official Plan document will always govern if there is any conflict between that document and this Summary. Likewise, any confusion about the Plan that arises from reading this Summary should be resolved by referring to the Plan document (and separate trust agreement, if applicable). This Summary does not interpret, extend or change the Plan in any way.

- ➔ Note that when you see this arrow symbol, you should be aware that an applicable Schedule at the end of this Summary more fully describes specific provisions of the Plan as it applies to you. Please refer to your specific Schedule as you review this Summary.

This Summary describes the Plan as it operates effective as of April 2016. **We strongly urge you to read this Summary (including the attached applicable Schedule) in its entirety.** If you have further questions, or if you would like to read the Plan document (and/or trust agreement, if applicable), copies of the documents are available from the Company for a nominal charge.

The following designated sections of this Summary constitute part of a prospectus covering NiSource stock in the Plan: Plan Overview, Amendment or Termination of the Plan, Administrative Information, Your Investment Options, Available Stock Information, Eligibility and Enrollment, Additional Information Relating to Investment

Options, Employee Contributions, Company Contributions, Plan Statements, Tax Consequences, Receiving Your Plan Benefit, In-Service Withdrawals, Benefits Paid to Other Parties, Situations Affecting Your Plan Benefits and Appendix 1. Further, with respect to the Available Stock Information section and Appendix 1, these portions of the document are included solely to satisfy certain prospectus disclosure requirements under Securities and Exchange Commission rules and are not considered to be parts of the Plan's SPD.

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

Highlights of the Plan

	ELECTIVE DEFERRAL CONTRIBUTIONS	AFTER-TAX CONTRIBUTIONS
VESTING	100% vested in your Elective Deferral Contributions, Catch-Up Contributions & the Company Contributions made to your Account and earnings	100% vested in your After-Tax Contributions and earnings
EMPLOYEE CONTRIBUTION **(See "Employee Contribution" Section)**	Can choose to contribute from 1% to 50% of your compensation. The maximum Elective Deferral Contribution under IRS limits for 2016 is $18,000	Can choose to contribute up to 25% of your compensation, subject to annual IRS limits (your combined Elective Deferral (including Catch-Ups) & After-Tax Contributions cannot exceed 75%)
"CATCH-UP" CONTRIBUTIONS AT AND AFTER AGE 50 **(See "Catch-Up Contributions" Section)**	$6,000 in 2016 *Catch-Up contributions are not eligible for match*	N/A
COMPANY CONTRIBUTIONS	See "Company Contributions" and attached applicable Schedule	See "Company Contributions" and attached applicable Schedule
ELIGIBLE COMPENSATION	See "Compensation" as referenced under the "Contributions" section and described in the attached applicable Schedule	See "Compensation" as referenced under the "Contributions" section and described in the attached applicable Schedule
TAX ADVANTAGES	For pre-tax contributions -- Your contributions *and* earnings are not taxed until distribution For Roth contributions – You pay taxes on your own contributions, but all earnings are tax free, even at distribution.	You pay taxes on your own contributions, but earnings are not taxed until distribution.
LOANS	Loans are available, subject to IRS rules and Plan restrictions	Loans are available, subject to IRS rules and Plan restrictions
IN-SERVICE WITHDRAWALS	• After age 59-½ • Company Contributions, under certain circumstances • Hardships	• Withdrawals of After-Tax Contributions can be made for any reason
DISTRIBUTION OPTIONS	• Lump Sum • Installments	• Lump Sum • Installments
SURVIVOR BENEFIT	Yes	Yes

PARTICIPATING IN THE PLAN

Eligibility and Enrollment

You must be an "**Eligible Employee**" to actively participate in the Plan (*i.e.*, to become a "**Participant**" in the Plan). Generally, if you are a regular full-time or part-time employee of the Company, you are eligible to participate in the Plan as of the first pay period after your employment begins, as described in the attached applicable Schedule. Leased employees, interns, independent contractors and union employees who are not covered by a collective bargaining agreement providing for participation in the Plan are not Eligible Employees.

➔ See the attached applicable Schedule for a description of when you become eligible to participate in the Plan.

How to Enroll

If you would like enroll in the Plan, or adjust the automatic Pre-Tax Contribution amount (see below), you may do so through the Fidelity Benefits Service Center. As a newly eligible Participant, you will receive an enrollment packet with the enrollment, beneficiary designation and investment option forms. You may enroll in the Plan online at NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015). To enroll, you will need to:

- Set up a Personal Identification Number (PIN);
- Elect what percentage of your Compensation you want to contribute to the Plan;
- Elect if your contributions should be deducted from your pay on a pre-tax, Roth (see "Contributions" section) or after-tax basis; and
- Elect the funds in which you want your contributions to be invested.

You will receive a written confirmation of the elections you make when you enroll in the Plan within 7 to 10 business days after enrolling. Alternatively, if you have elected to receive electronic communications regarding the Plan, you will receive a confirmation via email of your elections within 48 hours after enrolling.

Your actual payroll deductions will begin as soon as administratively possible.

Automatic Enrollment and Opting Out

Although participation in the Plan is voluntary, if the Plan's automatic enrollments provisions apply to you as described in the attached applicable Schedule, you will be deemed to defer a percentage of your Compensation (an "automatic Pre-Tax Contribution") unless you direct otherwise. If the Plan's automatic enrollment provisions apply to you and you were hired or rehired on or after January 1, 2015, your automatic Pre-Tax Contribution is 6%, unless otherwise provided on the attached applicable Schedule.[3] You may elect not to participate in the Plan (and avoid automatic enrollment) by contacting Fidelity Benefits Service Center at **1-800-305-401k** (4015) or online at **www.401k.com** and completing the necessary forms to "opt out" of automatic enrollment in the Plan. Provided you have returned any required forms or completed the online process, your opt out election will be effective as soon as administratively practicable following your Plan eligibility date or any following monthly date.

➔ See the attached applicable Schedule to confirm whether the Plan's automatic enrollment provisions apply to you.

[3] Unless otherwise provided on the attached applicable Schedule for you, if the Plan's automatic enrollment provisions apply to you and you were hired or rehired prior to January 1, 2014, your automatic Pre-Tax Contribution was 3%, and if you were hired or rehired between January 1, 2014 and January 1, 2015, your automatic Pre-Tax Contribution was 4%.

When Participation Begins

As an Eligible Employee, you can elect to be automatically enrolled in the Plan as described above (if the automatic enrollment provisions apply to you as described in the attached applicable Schedule). Alternatively, you can enroll in the Plan and become a Participant on the first pay period after you begin employment (or as soon as administratively feasible thereafter). To enroll in the Plan (or change deferral elections if you were automatically enrolled in the Plan), you can log on to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015). Typically, you can expect your deductions to begin one or two pay periods after enrollment. **Please note:** there are no retroactive deductions for pay periods that occurred prior to your enrollment being processed.

When Participation Ends

Your participation in the Plan ends when:

- You are no longer an Eligible Employee;
- The Company terminates its participation in the Plan;
- The Plan ends; or
- You die.

Participation Upon Re-employment

Once you become a Participant in the Plan, you will continue to participate in the Plan as long as you are an Eligible Employee of the Company. If you terminate employment with the Company, your participation in the Plan (*i.e.*, additional contributions going into your Account) stops automatically on your date of termination. If you terminate employment after becoming a Participant and later return to employment, you are eligible to participate in the Plan as soon as administratively practicable following the date on which you are re-employed. You must re-enroll in the Plan to begin participating after your re-employment. Alternatively, if applicable and if you do not re-enroll in the Plan after your re-employment, you may participate in the Plan again pursuant to the automatic enrollment and opt out provisions described above.

CONTRIBUTIONS

Your retirement benefits from the Plan will be funded from contributions you and the Company make to your Account and from your Account's earnings on these contributions. A number of different types of contributions may be made, and different rules and conditions apply to each type of contribution. Some of the different types of contributions are based on or affected by your "Compensation" from the Company (as defined in the attached applicable Schedule). For all employees, Compensation shall include any differential wage payments made by the Company while an employee is on active duty in the uniformed services for a period of more than 30 days, and any one-time payments in lieu of salary increases. The Internal Revenue Service ("IRS") limits the amount of your Compensation that can be considered under the Plan. The limit is $265,000 for 2016.

➔ See the attached applicable Schedule for a description of how the Plan calculates your Compensation.

Employee Contributions

Elective Deferral Contributions and After-Tax Contributions

You may elect to have the Company make Elective Deferral Contributions (explained below) and After-Tax Contributions to your Account by electing to reduce the Compensation otherwise payable to you. As a Participant, you can elect to contribute by payroll deductions from 1 percent to 50 percent of your eligible Compensation on a combined pre-tax or Roth basis ("**Elective Deferral Contributions**") and up to 25 percent on an after-tax basis ("**After-Tax Contributions**"). Your combined Elective Deferral Contributions (including Catch-Up Contributions explained further below) and After-Tax Contributions cannot exceed 75 percent of your Compensation (subject to annual IRS limits).

The maximum amount you may contribute annually to the Plan as an Elective Deferral Contribution for 2016 is $18,000 (unless you are eligible to make additional Elective Deferral Contributions known as "**Catch-Up Contributions**," explained below). Periodically, this limit will be further adjusted by the IRS to reflect changes in the cost of living.

Under the Plan, there are **two types of Elective Deferral Contributions**:

- **Pre-Tax Contributions**. Currently, you may make Elective Deferral Contributions to the Plan by reducing your Compensation on a pre-tax basis in a specified percentage ("**Pre-Tax Contributions**"). All of your Pre-Tax Contributions are generally made before taxes are withheld. This means that you generally pay no federal or state income tax on the amount you defer until it is later withdrawn or paid to you as a retirement benefit.
- **Roth Contributions:** You may also elect to have all or a portion of your Elective Deferral Contributions under the Plan treated as designated Roth contributions ("**Roth Contributions**"). Roth Contributions are still considered Elective Deferral Contributions, but unlike Pre-Tax Contributions, Roth Contributions are included in your gross income and are taxed at the time they are contributed to the Plan. Qualified distributions of Roth Contributions and earnings will be tax free.[4]

Accordingly, you can elect to make Pre-Tax Contributions, Roth Contributions, or both, subject to the limitations stated above ($18,000 for 2016 or, if less, 50% of your Compensation). As noted above, in addition to these Elective Deferral Contributions, you may also elect to make After-Tax Contributions to your Account. While After-Tax Contributions and Roth Contributions are both contributed on an after-tax basis, these two kinds of contributions are different under the Plan and subject to different rules and restrictions. Please consider them separately when making your Plan contribution decisions.

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[4] In order to be a qualified distribution, the distribution must occur after one of the following: (1) your attainment of age 59½, (2) your disability (as defined by the Internal Revenue Code), or (3) your death. In addition, the distribution must occur after the expiration of a 5-year participation period beginning in the year in which you first make a Roth Contribution to the Plan (or to another plan if such amount was rolled over into the Plan) and ending 5 years later. If a distribution is not a qualified distribution, the earnings will be taxable income (though the distribution of associated Roth Contributions will still be tax-free).

Automatic Contributions

If the Plan's automatic enrollment provisions apply to you (as described in the applicable Schedule and discussed above), unless you elect otherwise, you will be automatically enrolled in the Plan as of the first pay period that is 30 days from the date you are notified of the automatic enrollment. This means that amounts will be taken from your Compensation and contributed to the Plan by the Company on your behalf. These automatic contributions (also considered "Elective Deferral Contributions") will be made on a pre-tax basis and will be in the amount of 6% of your Compensation each pay period, unless otherwise provided on the applicable attached Schedule for you. You can elect to make more or less than this percentage amount as described below (see "Changing Your Contributions").

➔ See the attached applicable Schedule to confirm whether and how the Plan's automatic enrollment provisions apply to you.

Catch-Up Contributions

If you reach age 50 during the calendar year and you are making the maximum Elective Deferral Contribution allowed by the Plan or the Internal Revenue Code, you may make an additional Elective Deferral Contribution (either as a Pre-Tax or Roth Contribution or a combination of both) in the form of a Catch-Up Contribution each pay period. The maximum annual Catch-Up Contribution for 2016 is $6,000.

Catch-Up Contributions are a part of your Elective Deferral Contributions in your Account and they are fully vested and nonforfeitable at all times. Please note that these Catch-Up Contributions are not matched by the Company.

Changing Your Contributions

You may change the amount you are contributing at any time during the year, subject to any IRS limits that may apply. To increase or decrease the amount you are contributing or to suspend your contributions, go online to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Transactions are processed the same business day for transactions made by the time the market closes and the end of the next business day if you make a transaction after such time, or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days, or, if you have elected to receive electronic communications regarding the Plan, you will receive an email confirmation of your transaction within 48 hours. It can take up to two payroll checks for your contribution change to be processed.

Automatic Increase Program

If you would like to contribute a smaller percentage of your Compensation and automatically increase that amount over time, the Plan offers an "Automatic Increase Program" in which you can elect to participate. Under this voluntary program, you can elect to contribute a percentage of your Compensation to the Plan, which will automatically increase in 1% increments up to the limits imposed by the Plan or the IRS. In other words, after you elect to enroll in the Automatic Increase Program, unless you change your Automatic Increase Program election, the automatic increases will continue until you reach an applicable limit. Under the program, you may choose the date and frequency that the increases go into effect. Note that the Automatic Increase Program applies only to Pre-Tax Contributions you elect to make, and does not apply to Roth Contributions. For more information or to enroll, go online to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Rollover Contributions

You are permitted to roll over into the Plan pre-tax contributions from other qualified plans such as:

- Qualified retirement plans;
- Individual Retirement Account (IRAs);
- 403(b) plans; or
- Governmental 457(b) retirement plans.

By rolling over money into the Plan, you can continue to defer federal and state income tax on the money until you ultimately receive it. Rollovers are deposited into a Rollover Contribution Account within your Plan Account. You will not receive a matching contribution on any rollover you make to the Plan.

You may also be able to roll over Roth contributions from another qualified retirement plan. Note that with respect to Roth Contributions, you must satisfy a 5-year-taxable period before a distribution of Roth Contributions will be afforded the full taxation benefits available. This 5-year-taxable period will be treated as beginning with the earlier of (1) the first taxable year for which you made a Roth Contribution to the Plan, or (2) in the case of a rollover of Roth contributions from another plan, the first taxable year for which you made a Roth contribution to such plan. For more information on the rollover or distribution of Roth Contributions, see the "Contributions" and "Rollovers" portions of the "Tax Consequences" section later in this Summary.

If you want to arrange a rollover, call Fidelity Benefits Service Center at **1-800-305-401k** (4015) for more information. Note that you must specifically designate how rollover funds will be invested (i.e., rollover funds are not automatically invested in the manner you have chosen for the rest of your Account). Thus, if you arrange for a rollover contribution but fail to designate how those funds will be initially invested, the rollover amount will be invested in a default investment fund or funds established by the Committee.

Company Contributions

In addition to the contributions noted above that you can make to the Plan, you will also receive certain contributions made by the Company as described in the attached applicable Schedule.

Company "**Matching Contributions**" are additional contributions made by the Company to your Account based on the amount of Elective Deferral Contributions (but excluding Catch-Up Contributions) that you elect to contribute to your Account. In addition, as described in the attached applicable Schedule, the Company may also make Matching Contributions based on your After-Tax Contributions, if any.

All Company Matching Contributions will be made to the Company Stock Fund (unless provided otherwise in the attached applicable Schedule). Once the Matching Contributions are in your Account, you may diversify them immediately and at any time among any of the investment options available under the Plan.

The Company makes Matching Contributions each pay period. Once you reach the IRS limit on Elective Deferral Contributions and/or the combined Plan limit of Elective Deferral and After-Tax Contributions, you will no longer receive a Company Matching Contribution for Elective Deferrals and After-Tax Contributions (if applicable) contributed for the remainder of that calendar year.

There may be circumstances (*e.g.*, participation for only part of the year or changes in your deferral percentage during the year) under which, at the end of the year, your total Company Matching Contributions based on the applicable definition of Compensation do not total at least the percentage specified on the attached Schedule that is applicable to you. If this happens to you, the Company will make an additional Company Matching Contribution (called a "true-up" contribution) to your Account, so that you receive the maximum Company Matching Contribution for the year, when considering your total Elective Deferrals (and After-Tax Contributions if applicable) and total Compensation for the year.

- ➔ See the attached applicable Schedule for details on the Company Matching Contributions that you may receive.

In addition to Company Matching Contributions, you may also receive certain contributions from the Company that are not dependent on the amount of Elective Deferral Contributions you make to the Plan. **Please see the attached Schedule that is applicable to you for an explanation of these additional Company Contributions**.

INVESTMENT OF ACCOUNT BALANCES

All contributions are deposited in the Plan's Trust Fund. The Plan generally permits you to direct the investment of your Account balance as described below. Your investment elections and the various investment options under the Plan are managed by the Plan's Trustee who is appointed by the Committee. The Committee may also employ professional investment advisors to assist in carrying out investment responsibilities. The Committee reserves the right to change investment procedures. In addition, the Committee may change the type and number of investment options which are available to you from time to time.

Note that the Trustee may invest Plan assets in short-term, interest-bearing investments or maintain in cash certain portions of the available funds during periods prior to distribution or investment, or when money is being transferred from one investment option to another. The Trustee selects the short-term investment vehicles to be used for this purpose.

Your Investment Options

The Plan offers a variety of investment options, each with a different objective. At the time of your enrollment, you must make your investment choices in whole 1% increments. For more complete information on the Plan's investment options, including historical fund performance, fees and expenses visit Fidelity NetBenefits at **www.401k.com,** log in and click on the plan name (NiSource Inc. RSP) and click on Investment Performance and Research,, or visit the interactive tools on NetBenefits at **www.401k.com**. Additional help is available by calling the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

For a brief description of the investment options available under the Plan, please refer to the Appendix at the end of this document. Periodically, you will receive information about changes in the investment options available to you. Please refer to this information and the information on Fidelity's website (see above) for the most up-to-date information on your investment options.

Investment Options for Automatic Pre-Tax Contributions

If you are automatically enrolled in the Plan (under the automatic enrollment process explained above), your automatic Pre-Tax Contributions will initially be invested in a default investment fund or funds established by the Committee in compliance with applicable rules and regulations established by the Department of Labor. Currently, the Committee has designated the FIAM Target Date Funds as the default investment option for automatic contributions (see attached Appendix for further information). Unless you elect otherwise, your automatic contributions will be invested in the appropriate FIAM Target Date Fund based on your age and anticipated date of retirement. You may subsequently change this default investment by following the procedures explained in the "Changing Your Investment Election" section.

Investment Options for Company Contributions

The Company Contributions you receive are automatically invested in the NiSource Stock Fund (unless provided otherwise in the attached applicable Schedule). You can redirect that money at any time into any of the other investment options available under the Plan.

You can elect whether to reinvest your dividend from the NiSource Stock Fund or receive it in cash. However, if the dividend is less than $10, it will automatically be reinvested. If you do not make an election, your dividend will automatically be reinvested.

If you elect to receive your dividend in cash, it will be subject to income taxes in the year you receive it. However, it is not subject to the 10% penalty tax that applies to premature distributions from your Plan. No taxes will be withheld from your dividend check. You will be responsible for making all tax payments when you file your income tax return. Applicable tax forms will be provided to you by Fidelity.

To make an election, contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Changing Your Investment Election

You may make investment transfers (reallocations) at any time. You can move in percentages, dollar amounts, or number of shares among investment options. To make transfers in your Account, log on to NetBenefits at **www.401k.com**, or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

There is generally no limit to the number of times you may change your investment elections per year, but you can make only one change per day. There may, however, be short-term trading and excessive trading restrictions as outlined in the prospectus for each investment option. Transactions are processed the same business day for transactions made by the time the market closes and the end of the next business day if you make a transaction after such time, or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days.

Special Note Regarding the Columbia Pipeline Group Stock Fund

One of the investment options in the Plan is the Columbia Pipeline Group Stock Fund (the "CPG Stock Fund"). The CPG Stock Fund is included in the Plan as a result of the July 1, 2015 corporate spin-off of Columbia Pipeline Group, Inc. from NiSource Inc. The CPG Stock Fund is a frozen fund in the Plan, meaning that you may transfer account balances out of the CPG Stock Fund, but may not deposit new contributions into the CPG Stock Fund for any period that it is an investment option under the Plan. The CPG Stock Fund will be eliminated as an investment option under the Plan as of July 1, 2016 and will not thereafter be offered as an investment option under the Plan. If you have not taken action with respect to your Account balance invested in the CPG Stock Fund prior to the elimination, any CPG Stock remaining in the CPG Stock Fund will be liquidated and the proceeds will be automatically invested in the Plan's default investment option, which is the appropriate FIAM Target Date Fund based on your age and anticipated date of retirement.

See the attached Appendix containing the Plan's investment funds and performance for additional information regarding the CPG Stock Fund.

Additional Information Relating to the Investment Options

Investment Funds

The value of Plan accounts invested in a fund other than the NiSource Stock Fund will be net of any investment manager fees that may be charged with respect to that particular fund. The prospectus for each fund describes the fees and expenses associated with investing in that fund. You will not be charged any fees or expenses with respect to investments in the NiSource Stock Fund. In addition, for any period that the CPG Stock Fund is an investment option under the Plan, you will not be charged any fees or expenses with respect to investments in the CPG Stock Fund.

Equity securities in the funds, except for the NiSource Stock Fund and the CPG Stock Fund, will be voted by the Trustee. If any portion of your Account is invested in the NiSource Stock Fund or the CPG Stock Fund, you are entitled to exercise any voting, tender or similar rights attributable to the shares of such stock that are allocated to your Account. The Company will furnish the Trustee with notices and information statements when voting, tender and similar rights are to be exercised. The Trustee will notify you of each occasion for the exercise of voting, tender and similar rights and will forward copies of any proxy material within a reasonable time after it is secured from the Company or the issuer of the stock. You may elect to exercise your right by filing written voting or tender instructions with the Trustee at the time and in the form specified by the Trustee. Any instructions that you submit to the Trustee will be held in the strictest confidence and will not be divulged or released to any person including officers, directors or employees of the issuer of the stock. The Plan Administrator will establish procedures designed to safeguard the confidentiality of information as to your purchase, holding and sale of interests in the NiSource Stock Fund and the CPG Stock Fund, and your exercise of voting, tender and similar rights with respect to common stock held therein (except to the extent necessary to comply with federal laws or with state laws that are not preempted by ERISA). The Trustee will not tender shares of stock allocated to your Account if it does not receive your instructions by the specified deadline. With respect to voting of shares, if you do not provide instructions by a deadline specified for a voting matter, the Trustee shall vote shares of the applicable stock allocated to your Account in the same proportion as it votes shares for which the Trustee did receive instructions.

If you exercise your tender rights, the proceeds obtained when your shares of such stock are sold will be invested in the available investment funds, other than the NiSource Stock Fund (if applicable) or the CPG Stock Fund, in the same proportions as are included in your investment election on file with the Plan.

Accounting Methods Used for Record Keeping

The Plan uses units rather than shares to account for contributions to the NiSource Stock Fund and the CPG Stock Fund. This means that your investment in these funds is maintained in units, not actual shares. Each unit has a value that is calculated by dividing the total market value of the fund by the total number of units held in the fund. The number of units you hold in the fund increases or decreases as you make contributions, withdrawals, or transfers into or out of the fund. The value of your Account in the fund at any time is equal to the unit value multiplied by the number of units you hold. To find out the approximate number of actual shares of stock represented in the NiSource Stock Fund or the CPG Stock Fund, divide the fund value by the current share price of the applicable stock.

The other investment funds are subject to share accounting, which means that your investment in these funds is maintained in actual shares of the fund. Thus, shares are bought and sold to cover your contributions, withdrawals or transfers into or out of the fund.

Purchase and Sale of Stock Fund Holdings

NiSource stock and Columbia Pipeline Group Stock are listed on the New York Stock Exchange. The Plan generally purchases or sells NiSource or Columbia Pipeline Group stock as soon as administratively possible after it receives any election by a participant to transfer amounts invested in this option. Each such purchase or sale will be made at the market price for the applicable stock on the New York Stock Exchange at the time of the purchase or sale.

Section 16 of the Securities Exchange Act of 1934

If you are subject to the short-swing profit provisions of Section 16 of the Securities Exchange Act of 1934 (an “insider”), you may be limited in your ability to purchase and sell NiSource stock under the Plan. Further information covering the operation of Section 16 to insiders will be provided by the Company.

Resale Restrictions

Although the Company has registered the sale of NiSource stock pursuant to the Plan, special restrictions may apply to the resale of the shares distributed to you from the Plan if you are an “affiliate” of the Company at the time of the resale, as such term is used in Rules 144 and 405 of the Securities Act of 1933. An affiliate of the Company may not reoffer or resell NiSource shares without further registration under the Securities Act of 1933 unless the reoffer or resale is pursuant to an applicable exemption, such as Rule 144. Generally, only the Company’s executive officers would be considered affiliates of the Company. Any person who may be an affiliate may wish to consult with legal counsel before transferring any NiSource stock.

For More Information About Plan Investments

Additional information about the investment options offered by the Plan is available upon request. You may request information regarding each investment option (*e.g.*, annual operating expenses, prospectus documents, financial statements, reports and other materials) by contacting the Fidelity Benefits Service Center at **1-800-305-401k** (4015) or visit the interactive tools on NetBenefits at **www.401k.com**.

Results of Recent Performance of the Investment Options

The Appendix found at the end of this document includes certain information about the relative historical performance of each of the currently available investment funds. Participants are advised that past performance is not necessarily indicative of the future performance of these funds. As previously stated, periodically, you will receive materials that update the information found in the attached Appendix. Contact the Fidelity Benefits Service Center if you have questions about the investment options.

Limiting Investment Liability

The Plan is intended to meet the provisions of Section 404(c) under ERISA. This means that Plan fiduciaries (those responsible for administering the Plan) may be relieved of liability for losses resulting from your investment instructions.

As a Plan participant, you may request (and the Plan fiduciary must provide):

- A description of the annual operating expenses of each investment option (*e.g.*, investment management fees, administrative fees and transaction costs) which reduce the rate of return to participants, and the total amount of such expenses expressed as a percentage of the investment option's average net assets.
- Copies of any annual reports, financial statements and reports, and any other materials relating to the investment options available under the Plan, to the extent such information is provided to the Plan.
- A list of the assets in the portfolio of each investment option; the value of each asset (or the proportion of the investment option which it comprises); and the fixed-rate investment contracts, the name of the bank, savings and loan association, or insurance company issuing the contract, the term of the contract and the rate of return of the contract.
- Information concerning the value of shares or units in the available investment options, as well as the past and current investment performance determined, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment options held in your Account.

Available Stock Information

The Company is offering a maximum of 10,500,000 shares and an indeterminate number of participation interests in connection with the NiSource Stock Fund of the Plan. These shares were registered on the Company's Form S-8 filed on November 19, 2010 (File No. 333-170706) (the "Registration Statement").

The Company and the Plan are required to file documents with the SEC pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities and Exchange Act of 1934. All such documents filed by NiSource or the Plan after the effective date of this SPD will be considered incorporated by reference in the Registration Statement and this SPD and Prospectus until the Company or the Plan files a post-effective amendment that states that all NiSource stock offered by the Registration Statement has been sold, or deregisters all NiSource stock that remains unsold. Incorporated by reference into this Prospectus are the following documents and information filed with the SEC:

- NiSource Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015 (filed February 18, 2016) (File No. 001-16189);
- The Plan's Annual Report on Form 11-K for the year ended December 31, 2014 (filed June 25, 2015) (File No. 001-16189);
- All other reports NiSource Inc. has filed pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 since December 31, 2015 (File No. 001-16189); and
- The description of NiSource Inc. Common Stock set forth under the caption "Description of Capital Stock" contained in NiSource's Amendment No. 1 to Registration Statement on Form S-4, filed on April 24, 2000 (File No. 333-33896-01), together with any amendment or report filed with the Commission for purposes of updating such description.

The Company will provide, without charge to each Plan participant, upon his or her written or oral request: (i) a copy of any of the documents incorporated by reference in the Registration Statement other than exhibits to such documents which are not specifically incorporated by reference into the information that this document incorporates, and (ii) a copy of its Annual Report to Shareholders for its most recent fiscal year. Requests for copies of these documents should be directed to the Plan Administrator as follows:

NiSource Inc.
Attention: NiSource Benefits Committee

801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

IN-SERVICE WITHDRAWALS

Access to Your Account While Employed

In general, the Internal Revenue Code contains restrictions on when you can get access to money that has been set aside in your Account in the Plan. These restrictions are imposed because of the tax benefits you receive in conjunction with making contributions to the Plan. The Plan generally does not allow you to withdraw any portion of your Account prior to the time that you terminate employment, retire, become disabled, die, or reach age 59½.

You are, however, permitted to obtain access to your Account or portions of your Account under certain circumstances. If you meet certain requirements, you may make a loan withdrawal from the Plan. In addition, you may be permitted to access your Account in the event of financial hardship. Finally, as explained below you may withdraw any After-Tax Contributions or Rollover Contributions that you have made to the Plan at any time while you are an active employee, and certain Company Contributions.

Except as otherwise provided in the Voluntary Withdrawals subsection below, any amounts withdrawn will be taken pro-rata from the various investments in which your Account is invested. Withdrawals from your Account invested in the Company Stock Fund or any other stock fund maintained under the Plan may be made in cash and/or stock at your request. Note that, like distributions upon termination, in-service withdrawals from your Account can have tax implications. You should consult your own tax advisor concerning any distribution that you receive from the Plan.

Loans

You may apply for a loan from the Plan while you are still an active employee by logging on to NetBenefits at **www.401k.com** or contacting the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

- When you take a loan from the Plan, you are borrowing from yourself and paying your Account back with interest. If you pay your loan back as agreed, your loan is not subject to income or penalty taxes.
- You may borrow from your Account for any reason.
- You may have up to two loans outstanding at any time from all Company-related retirement savings plans. Note if you pay off one of two outstanding loans, there is a 14-day waiting period before you can apply for a new loan.
- The minimum loan amount is $1,000.
- The maximum loan amount is the lesser of: (1) $50,000 reduced by any outstanding loan balances over the previous 12 months; and (2) 50 percent of your total vested account balance. Loan repayments, plus interest, are automatically deducted from your paycheck through after-tax payroll deductions.
- Loans are taken from your investment options on a pro rata basis.
- The loan term can be from one to five years (15 years if the loan is to purchase your primary residence), as long as you will receive a paycheck in an amount at least as much as the loan repayment each pay period. You may also make a lump-sum repayment of the full amount remaining on your loan balance at any time. However, lump-sum payments of only a partial amount of your outstanding loan will not be accepted.
- The interest rate applied on these loans is the prime rate supplied by Reuters on the last day of the previous month.
- You can repay your loan(s) in full and without penalty at any time.
- If you fail to make any required loan payments, the balance of your loan (and any other charges or expenses incurred because of your default) will be treated as a taxable distribution to you on your default date and will be deducted from your Plan Account. Note that defaulted loans can prevent you from taking additional loans from your Plan Account in the future.

- If you are on leave due to disability (as defined by the Plan) and cannot repay your loan because your leave is unpaid or paid at a rate below your scheduled loan repayments, your loan repayments may be suspended for up to one year, provided that your loan is repaid within the IRS-mandated maximum period. If you are on a qualifying leave for active military service, your loan repayments may be suspended regardless of pay, and your loan repayment period may be extended by the duration of your military leave.
- If your employment with the Company terminates or if you no longer receive compensation from the Company (*e.g.*, you are receiving long-term disability benefits), payments of principal and interest on any outstanding loan may be made through direct debit from your bank account, in accordance with the electronic loan payment procedures established by the Plan Committee. If you do not authorize payments through direct debit from your bank account, your outstanding loan will be considered in default.
- Loans are processed and serviced by Fidelity. A $50 loan origination fee will be deducted from your 401(k) Account for each loan.
- Typically, you can expect to receive a check within five to eight business days after your loan is approved. Your signature on the back of the check will indicate your approval of the loan terms contained in the accompanying paperwork.

Hardship Withdrawals

You can withdraw up to your entire Account balance (except for earnings on your Elective Deferral Contributions from and after January 1, 1989) for financial hardships as defined by the IRS. *Investment earnings cannot be withdrawn until you reach age 59 ½ or leave the Company.*

IRS regulations currently define hardship withdrawals as:

- Purchase of your primary residence (but not mortgage payments);
- Tax deductible medical expenses for yourself, your spouse, your dependents or your beneficiary;
- Tuition and related educational fees (including room and board) for up to the next 12 months of post-secondary education for yourself, your spouse, your dependents or your beneficiary;
- Prevention of eviction from, or foreclosure on, your primary residence;
- Funeral expenses for your spouse, your dependents or your beneficiary;
- Expenses for the repair of damage to the Participant's principal residence that would qualify for the casualty deduction under Code Section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income); or
- Any other need as the Committee, or its delegate, determines to be a hardship expressly specified in Treasury Regulations announced by the Commissioner of the Internal Revenue Services issued under Code Section 401(k).

You will have to provide documentation of the hardship showing an immediate and serious financial need and the amount required to meet the hardship. Your withdrawal cannot be more than the amount required to meet the financial hardship, plus a reasonable estimate of amounts needed to pay federal, state or local income taxes or penalties, up to certain limits. A hardship withdrawal is considered taxable income to you, and if you are not yet age 59½, may also be subject to a 10% penalty tax.

When you take a hardship withdrawal, the IRS and the Plan also impose certain other rules that will affect your Plan participation:

- If you can take a loan from the Plan, you must take a loan up to the maximum amount available prior to applying for a hardship withdrawal—unless repaying the loan in itself would be a hardship.
- If you maintain any investments in the Company Stock Fund, you must elect to receive any dividends attributable to your Account invested in the Company Stock Fund.

- You will need to withdraw any available After-Tax Contributions, Rollover Contributions and Company Matching Contributions, to the extent available, plus the earnings on those contributions first.
- If you take a hardship withdrawal, you will not be allowed to contribute to the Plan for six months. (If you take more than one hardship withdrawal, each six-month suspension period will run concurrently.) Following the six-month suspension period, you will be automatically reinstated into the Plan at your previous deferral percent and investment elections that were in effect prior to the hardship suspension period.
- You will also need to sign a statement indicating that other financial resources have been exhausted.

Other In-Service Withdrawals

In addition to loans and hardship withdrawals, you may be able to make the following withdrawals from your Account while you are an active employee:

- Withdrawals of any amount of your vested Account after age 59½;
- Voluntary withdrawals from the After-Tax Contributions, Rollover Contributions, Company Contributions in your Account; or
- Withdrawals during military service.

You can request a minimum withdrawal of $250 (or your entire balance, if lower). Distributions will be taxed as ordinary income in the year withdrawn and may also be subject to an early withdrawal penalty if taken before age 59 ½, unless eligible rollover distributions are rolled over to another qualified plan or an IRA. (This excludes any withdrawals of After-Tax Contributions.) A 20% mandatory federal income tax withholding applies to withdrawals that are eligible for rollover that are not directly rolled over to another qualified plan or an IRA.

For more information or to request a withdrawal, log on to NetBenefits at **www.401k.com** or contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

Withdrawals After Age 59½

Once you reach age 59½, you are eligible to make withdrawals from all or a portion of your vested Account balance in the Plan. Your distribution will be processed as soon as administratively practicable following your request for withdrawal.

Voluntary Withdrawals (After-Tax, Rollover, Company Contributions)

If you have made After-Tax and/or Rollover Contributions to the Plan, you may make a full or partial withdrawal of those funds while you are an active employee. Although you are not taxed on the withdrawal of your After-Tax Contributions, you will be taxed on your Rollover Contributions and earnings on both your After-Tax and Rollover Contributions.

Unless the attached applicable Schedule provides otherwise, you may withdraw any portion or all of your Company Contributions from your Account, provided that you have been a Participant in the Plan for at least 60 months. If you have been a Participant in the Plan for less than 60 months, you generally may not withdraw your Company Contributions. (However, if you had Company Contributions made on your behalf prior to July 1, 2009 and on that date you had been a Participant in the Plan between 24 and 60 months, then you may have the ability to withdraw part of your Company Contributions regardless of whether you have completed 60 month of participation. See the Plan Administrator for additional details.) If you are withdrawing Company Contributions, you will be taxed on your withdrawal.

Withdrawals are funded by a pro-rata withdrawal from your investment options, unless otherwise requested with respect to the Company Stock Fund or any other single employer stock fund offered under the Plan, and are made in cash, unless otherwise specifically requested for the Company Stock Fund or any other single employer stock fund (if applicable). Contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015) for additional details.

Withdrawals During Military Service

Effective as of January 1, 2009, you may be eligible to make a withdrawal from your vested Account balance in the Plan if you are performing active service in the uniformed services for a period of more than 30 days. If you qualify for this withdrawal right, you may request withdrawal of all or a portion of your vested Account balance. However, if you elect to receive such a withdrawal, you will not be allowed to contribute to the Plan for six months from the date of withdrawal. Following the six-month suspension period, you will be automatically reinstated into the Plan at your previous deferral percent and investment elections that were in effect prior to the withdrawal suspension period.

RECEIVING YOUR PLAN BENEFIT

When Your Benefit is Paid

You or your beneficiaries are entitled to receive the full value of your Account as soon as possible after:

- You terminate employment with the Company;
- You qualify for disability under the Plan; or
- You die.

If your Account balance is $5,000 or less when you terminate employment, the Plan Administrator automatically pays you your Account balance as soon as administratively practicable following your termination. See the following "Forms of Benefit Payment" section for an explanation of how this automatic distribution may be made. Otherwise, if the value of your Account is over $5,000, you can elect to receive the value of your Account, or you may defer payment to a later date. *If you defer payment to a later date, your Account will remain invested in the Plan's investment options. You can change your investment option election at any time under the regular rules of the Plan.*

By law, you must begin to receive payment of your Account balance by the 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.

Forms of Benefit Payment

Regardless of when you elect to receive your benefit, your Account balance will be distributed to you (or your beneficiary) in one of the following forms:

- *Lump Sum* (Your entire benefit paid directly to you or rolled over to an Individual Retirement Account/Annuity ("IRA") or another employer's retirement plan);
- *Partial Lump Sum* (A portion of your benefit paid directly to you or rolled over, as described above, and the remaining portion of your benefit paid at a later date); or
- *Installments (annual, semi-annual, quarterly or monthly)* (Your benefit paid in regular installments directly to you or in certain instances, as a rollover).

Note that if your Account balance is less than or equal to $5,000 at your termination, you are not eligible to elect installment payments. Instead, the Plan automatically pays your benefit as a lump sum, which you can elect to receive directly or roll over to an IRA or another employer's retirement plan. If you (or your surviving spouse in the event of your death) do not make an election (direct payment vs. rollover), then the Plan will pay your benefit as follows: (1) if your Account balance is $1,000 or less, the Plan Administrator will pay your benefit directly to you as a lump sum payment; (2) if your Account balance is more than $1,000 but less than or equal to $5,000, the Plan Administrator will roll your balance to a designated IRA. See "Rollovers" found later in this Summary for further information on rollovers generally.

Unless you elect otherwise, the balance of your Account invested in the Company Stock Fund will be distributed in installments of not more than five years (unless such balance exceeds a certain limit). You may request that your Account in the Company Stock Fund be paid to you in shares of Company common stock, in cash or in a combination of the two.[5]

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[5] In addition, for any period that the CPG Stock Fund is an investment under the Plan, distribution of units of the CPG Stock Fund may also be requested in stock, in cash or in a combination of the two.

DEATH BENEFITS

If you die before your Account balance has been paid to you, the Plan will distribute your Account balance as a death benefit to your surviving spouse or other beneficiary you have named under the rules of the Plan (provided the proper forms have been filed) as described below. No separate death benefit is payable after your Account balance has been distributed from the Plan.

Form and Timing of Death Benefit

Your Account balance will be paid to your surviving spouse or other named beneficiary in one of the following forms:

- Lump Sum (full or partial, but subject to any death benefit timing requirements)
- Installments (annual, semi-annual, quarterly or monthly)

In general, any death benefit payment(s) of your Account can be made as soon as administratively practicable following your death and after filing any required paperwork. In any event, your entire Account will be distributed to your beneficiary, or to the parties listed in the portion of the "Designation of Beneficiary" section below that applies if you fail to designate a beneficiary, by the fifth anniversary of your death.

In addition, your beneficiary may be able to roll over your Account balance to an IRA or another retirement plan. See the "Rollovers" portion of the "Tax Consequences" section later in this Summary for more information.

If you have outstanding Plan loans at the time of your death, your beneficiary may elect to pay off the remaining balance. If your beneficiary does not pay off the balance, the balance (and any other charges or expenses incurred because of the default) will be treated as a taxable distribution and will be deducted from your Plan Account.

Designation of Beneficiary

When you enroll in the Plan or make a Rollover Contribution, you should name a beneficiary (someone to receive your benefits from the Plan in the event of your death) by completing a beneficiary designation online through NetBenefits at **www.401k.com**. You may also request a paper beneficiary designation form online or by calling the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

You may designate any person or persons, or a trust fund, as your primary beneficiary to receive death benefits that are payable from the Plan. You may also designate a contingent beneficiary who will receive your benefits in the event your primary beneficiary does not survive you.

If you are married: By law, if you are married, your spouse is automatically your beneficiary unless you designate someone else. If you wish to designate someone else, your spouse must give his or her consent in writing by signing the beneficiary designation form in the presence of a notary public or a Plan representative. The beneficiary designation form provided to you will contain a place for your spouse to sign to consent to your designation of someone else as your primary beneficiary. If you are married and your spouse will not consent to your designation of someone else, then this designation will not be valid and your spouse will be treated as your primary beneficiary. If your marital status changes, it is important that you complete a new beneficiary designation form. 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 are single: If you are single, you may name anyone as your beneficiary.

If you fail to designate a beneficiary, your benefits will be payable as follows:

- To your surviving spouse, or if none;
- To your descendants, per stirpes, or if none;
- To your father and mother, in equal parts, or if none;

- To your brothers and sisters, in equal parts, or if none;
- To your estate.

You may change your beneficiary at any time by making a new beneficiary designation through NetBenefits at **www.401k.com**, or by requesting and submitting a new form. However, if you name someone other than your spouse, your spouse must give his or her consent by signing the beneficiary designation form in the presence of a notary public or a Plan representative.

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. *If your marital status changes, you must inform the Plan Administrator if by contacting the Fidelity Benefits Service Center at* **1-800-305-401k (4015)**.

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)

By federal law, the Plan must comply with a qualified domestic relations order (“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 obligations for the division of marital property rights, for child support or alimony. A QDRO may require that your former spouse be treated as the 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 Plan Administrator. You or your spouse should submit a draft version of a domestic relations order to the Plan Administrator for review and approval before such order is finalized under domestic relations law.

As soon as you are aware of any domestic relations proceedings that may affect your Account, contact the Plan’s QDRO administrator as follows: (a) call 1-888-858-5500; (b) send an e-mail to QOCenter@hewitt.com; or(c) visit the website at www.QOCenter.com. When the Plan Administrator receives notice of a pending QDRO, a hold will be placed on your Account that will prevent you from making any withdrawals, including any distributions, loans or hardship withdrawals, until the QDRO is processed.

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 a distribution under the Plan. Once you receive a benefit payment, however, you will have taxable income on this payment in the year your receive it. In the year 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.

The discussion of Federal income tax consequences that follows is included for general information only. It does not describe all relevant tax matters (such as state and local income and inheritance taxes and federal estate and gift taxes) that should be considered in connection with participation in the Plan and does not completely describe all provisions associated with the tax matters discussed. Accordingly, you should not rely exclusively on this discussion and are advised to consult a personal tax adviser for tax planning relevant to the Plan.

Withholding Requirements

Your benefit payments are subject to withholding for federal income taxes. (Note that your benefit payments may be subject to state and local taxes, including tax withholding, as well.) “Withholding” is an advance payment on federal income taxes that you may owe as a result of any Plan distributions that you receive. When making a distribution, the Plan is required by law to withhold 20% of your payment unless you make a direct rollover to an IRA (including to a Roth IRA) or to another retirement plan (see the Rollovers section below).

Contributions

The Plan is a qualified plan under Sections 401(a), 401(k) and 401(m) of the Internal Revenue Code. As a result, the amount of your Compensation that you elect to defer under the Plan through Pre-Tax Contributions, Company Contributions and Rollover Contributions, and any earnings thereon, are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts.

The amount of your Compensation that you elect to defer through Roth Contributions, in contrast, will not be subject to federal income taxes at distribution because these amounts were already taxed at the time they were contributed to the Plan. Earnings on Roth contributions will also not be subject to federal income taxes at distribution provided the distribution is a “qualified distribution.” A distribution of Roth Contributions is generally a qualified distribution if it has been in the Plan for five taxable years and is made after the earliest of your attainment of age 59-½, death or disability. If the distribution is not a qualified distribution, then the portion of the distribution representing your Roth Contributions will not be taxable to you, but the portion of the distribution representing earnings on the Roth Contributions will be taxable to you in the year you receive the distribution, unless you comply with the rollover rules as described below.

The amount of your Elective Deferral Contributions (Pre-Tax Contributions and Roth Contributions) will be included in your income in the year in which these amounts are considered earned for purposes of Social Security (FICA) taxes. In addition, some states, cities or counties may impose taxes on your Elective Deferral Contributions.

Although After-Tax Contributions are deducted from your Compensation after all applicable taxes have been withheld, the earnings on such contributions are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts.

Distributions

In addition to being taxed as ordinary income, the taxable portion of a distribution you receive from the Plan before you reach age 59 ½ may be subject to a nondeductible federal penalty tax of 10%, unless the distribution or withdrawal is (1) rolled over to another eligible retirement plan or to an IRA, (2) made to a beneficiary after your

death, (3) made on account of your termination due to disability, (4) made after you have separated from service with the Company, if the separation occurred during or after the year you reached age 55, (5) made to you for payment of medical expenses that could be deducted on your tax return, (6) paid in equal installments over your life or life expectancy or the lives or life expectancy of you and your beneficiary, or (7) made to an alternate payee pursuant to a qualified domestic relations order.

Note that these rules apply to in-service withdrawals as well as distributions upon termination of employment.

To the extent that you receive shares of Company stock, your tax liability is based on the value of the stock that is contributed to the Plan for the Company Matching Contributions to your Account. This value is taxed at ordinary income tax rates. Tax on any gain is deferred until you actually sell the stock. At that time, any gain is taxed at the capital gains tax rate.

Lump Sum Distributions

If you receive a lump sum distribution and you were born before January 1, 1936, (1) you can make a one-time election to figure the tax on the distribution by using "10-year averaging" at 1986 rates; and (2) you may elect to have the part of your distribution that is attributable to your pre-1974 participation in the Plan (if any) taxed as long-term capital gain at a rate of 20%. You generally can elect this special tax treatment only once in your lifetime and if you have previously rolled over a payment from the Plan, you cannot use this special tax treatment for later payments from the Plan. You should consult your tax advisers as to your eligibility for and the manner of electing this special treatment.

Rollovers

You generally can roll over a distribution or withdrawal of your Account to an eligible retirement plan that accepts rollovers or to an IRA, if the distribution is an "eligible rollover distribution" as defined in the Code. If you roll over a distribution of your Account to an eligible retirement plan or a traditional IRA, the amount rolled over and earnings thereon are not subject to income tax until subsequently distributed to you or your beneficiary. 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. As stated above, any taxable amount of an eligible rollover distribution that is not rolled over will be subject to a mandatory 20% withholding requirement.

You may roll over an eligible rollover distribution that consists of Roth Contributions and earnings (whether or not it is a qualified Roth distribution) either (1) by direct rollover to another 401(k) Plan or 403(b) Plan that accepts Roth Contributions, or (2) by direct rollover (or indirect rollover within 60 days of distribution) to a Roth IRA. Alternatively, you can roll over the taxable portion of a non-qualified Roth distribution by an indirect rollover within 60 days of distribution to a 401(k) or 403(b) plan that accepts Roth Contributions.

In addition, in the event of your death, your designated beneficiary may roll over a distribution of your Account. If your designated beneficiary is your spouse, he or she may elect to roll your Account over to another eligible retirement plan or an IRA. If you have designated a non-spouse beneficiary, the beneficiary may elect to roll your Account over from the Plan directly to an IRA established for the purpose of receiving the distribution.

A distribution or withdrawal is not an "eligible rollover distribution" and may not be rolled over, if it is (1) a series of substantially equal period installments over ten years or more, or over your life expectancy or the joint life expectancies of you and your beneficiary, (2) a required distribution due to your attainment of age 70-1/2 (or retirement if later), (3) a hardship distribution or (4) a distribution made to a non-spouse beneficiary before May 1, 2007.

A taxable distribution or withdrawal that is not an "eligible rollover distribution" is subject to voluntary Federal income tax withholding. Prior to receiving a distribution of any amounts from the Plan, you will receive a Notice of Tax Treatment to assist you in determining your tax liability. The rules governing the Federal income taxation of a distribution are complex and are subject to change, and you should seek the advice of your tax advisers in connection with a distribution from the Plan.

To make a direct rollover, you must contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015). A Fidelity representative will ask you for specific information on the IRA or the other employer's plan to which you are requesting the rollover and let you know if a rollover is available to you.

SITUATIONS AFFECTING YOUR PLAN BENEFITS

This section describes how the Plan provides you or your beneficiary with benefits. It is important that you understand the conditions under which benefits could be less than expected, not paid at all or otherwise limited, including:

- ***Investment Losses.*** If the investment funds you choose experience losses, the value of your contributions can decrease.
- ***Code Limitations.*** If you are affected by total annual contribution or compensation limits under the Internal Revenue Code, the amounts you and the Company contribute on your behalf may be limited. If you are affected by these limits, you will be notified.
- ***Nondiscrimination Testing.*** If the Plan does not pass required nondiscrimination testing, all or a portion of the contributions made on behalf of highly compensated employees may be reduced. Nondiscrimination testing is required by law to ensure a fair mix of contributions from and for employees at all income levels. If you are affected by these limits, you will be notified.
- ***Application Failures.*** If you fail to make proper application for benefits or fail to provide necessary information, your benefits could be delayed.
- ***Address Changes.*** If you do not keep your most recent address on file and the Plan Administrator cannot locate you, your benefit payment may be delayed. Once you (or your beneficiary, if you die) provide a current address, benefit payments can be made. Accordingly, if you are a current employee and experience a change of address, please give your new contact information to the Company's Human Resource Department. If you have terminated employment with the Company and experience a change of address, please provide your new contact information to the Company's Human Resource Department and provide this same information to the Fidelity Benefits Service Center at **1-800-305-401k** (4015).
- "***Top Heavy" Limitations.*** 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 percent of accumulated Account balances are payable to certain "key employees." Key employees are employees who are officers of the Company with annual compensation greater than $170,000, 1 percent owners of the Company with annual compensation greater than $150,000, 5 percent owners of the Company and beneficiaries of the above. You will be notified if this affects you.

CLAIMS FOR BENEFITS

Applying for Your Plan Benefit

You must file an application with the Plan Administrator in order to receive your benefits under the Plan. When an event occurs that entitles you to a distribution of your benefits under the Plan, the Plan Administrator will generally notify you that an application should be filed. In order to receive your benefit, you must complete and submit a benefit election form no more than 180 days before you are scheduled to receive your benefit.

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 or will not be paid, or are too low, or are or will be 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 benefit under the Plan 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;
- References 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 Plan 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. You must exhaust the claims and appeals procedures described in this section before you can institute these legal proceedings.

Indiana law shall determine all questions arising with respect to the provisions of the plan, except to the extent superseded by Federal law. Any 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 of the United States for the Northern District of Indiana.

Benefits Paid to Other Parties

The Plan is intended to pay benefits only to you or to your beneficiary. Your Plan benefit cannot be used as collateral for a loan, sold, transferred, garnished, or assigned in any other way. Your Account may generally not be sold, assigned, transferred, pledged or garnished under most circumstances. However, benefits may be divided in a court ordered property settlement in case of divorce or other situations that divide property (see the Qualified Domestic Relations Order" section earlier in this Summary).

If you become incapacitated and unable to manage your own affairs, the Plan may make any unpaid benefit payments to such person or entity that the Plan Administrator deems appropriate to receive distributions in order to provide for your comfort, maintenance and support. For instance, such person (or entity) may be a relative, guardian, person possessing a valid Power of Attorney, or an institution charged with your care or custody.

ADDITIONAL INFORMATION

Amendment or Termination of the Plan

The Committee reserves the right to suspend, amend or terminate the Plan at any time, in whole or in part. Generally, Account balances cannot be reduced except for investment losses, even by a Plan amendment. Termination of the Plan is unlikely, but if the Plan is terminated, your Account automatically will remain 100 percent vested. If any material changes are made to the Plan in the future, you will be notified.

The Committee may only amend the Plan in writing. Any amendments 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 a human resources representative, for instance. If you believe that you have received information that is contrary to the terms of the Plan or this Summary, please contact the Company for clarification or confirmation.

Benefits Are Not Insured

The Plan is a defined contribution plan providing specifically defined levels of contributions. This type of plan is not eligible for benefit insurance through the Pension Benefit Guaranty Corporation (“PBGC”), and no particular dollar level of benefits is guaranteed. All of the contributions are deposited with the Trustee. All payments of Plan benefits are made from the Plan’s Trust Fund.

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.

No Guarantee

The information in this SPD does not state or imply that participation in the Plan is a guarantee of continued employment with the Company, nor is it a guarantee that contribution levels will remain unchanged in future years.

Plan Expenses

Administrative expenses of the Plan, including fees of the Trustee, counsel, accountants or other experts appointed under the Plan, will be paid out of the Trust Fund to the extent not paid by the Company.

Plan Statements

As a Plan Participant, you will receive a statement of your Plan Account quarterly from Fidelity that shows your Account balance as of the end of the most recent quarter. You can elect to receive your statement online. You can view your statement online beginning the day after the end of the quarter and going back for 24 months. Check your statement to be aware of your Account activity. Please contact Fidelity within 60 days of receiving your statement if you think there is an error.

Your Account is valued by Fidelity at the close of every business day. You can call Fidelity Benefits Service Center at **1-800-305-401k** (4015) or log on to your Account at **www.401k.com** seven days a week to review your current Account balance.

ADMINISTRATIVE INFORMATION

Plan Sponsor

The Plan Sponsor is NiSource Inc.

Plan Administrator

The Plan Administrator is the NiSource Benefits Committee. The Plan Administrator has the sole authority to interpret the terms of the Plan in its discretion. For more information about the Plan and its administration, you may contact the Plan Administrator at:

NiSource Inc.
Attention: NiSource Benefits Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

Pursuant to authority granted in the Plan document, the Plan Administrator delegates various administrative functions to other entities or individuals, including Fidelity and the NiSource Human Resources Department. To the extent the context requires, reference to Plan Administrator in this Summary may include or mean one or more of these delegates.

Employer I.D. Number

The Employer Identification Number ("EIN") assigned by the IRS and associated with the Plan is 35-2108964.

Plan Type, Name and Number

The Plan is classified as a defined contribution plan and has been assigned Plan number 005. It also is a Code section 401(k) plan and an ERISA section 404(c) plan. The official Plan name is the NiSource Inc. Retirement Savings Plan.

Plan Year

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

Plan Trustee

The Plan Trustee is responsible for holding the assets of the Trust Fund according to the Participants' and the Company'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.

The trustee for the Plan is: Fidelity Management Trust Company
82 Devonshire Street
Boston, MA 02109

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Senior Vice President of Human Resources
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5571

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

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 (“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 from the Plan Administrator, once a year, a statement of your total benefits accrued and your nonforfeitable (vested) retirement benefits (if any), or the earliest date on which benefits will become nonforfeitable (vested). The Plan may require a written request for this statement, but it 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 benefit under the Plan 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, provided you have followed the claims procedures explained earlier in this Summary.
- If you disagree with the Plan’s decision or lack thereof concerning the qualified status of a Qualified Domestic Relations Order (“QDRO”), you may file suit in federal court.
- If it should happen that 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, 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.

A copy of the Plan document is on file at NiSource's corporate offices, 801 E. 86th Avenue, Merrillville, IN 46410. These documents may be read by you, your beneficiaries or your legal representatives at any reasonable time. Additionally, if you make a written request, you may receive a copy of the Plan document. You may be charged for the copies.

If you have any questions regarding either the Plan or this SPD, you should contact the Fidelity Benefits Service Center at **1-800-305-401k** (4015).

NISOURCE INC. RSP

Appendix 1

Understanding investment performance: As you review this update, please remember that the performance data stated represents past performance, which does not guarantee future results. Investment return and principal value of an investment will fluctuate; therefore, you may have a gain or loss when you sell your shares. Current performance may be higher or lower than the performance stated. To learn more or to obtain the most recent month-end performance, call Fidelity or visit www.401k.com (log in, choose plan, select Investment Choices & Research, and then pick investment option.).

				Cumulative Total Returns % Period Ending March 31, 2016			Average Annual Total Returns % Quarter Ending March 31, 2016					Calendar Year Returns						
Product Name:	**FPRS Code**	**CUSIP**	**Ticker**	**1 Month**	**3 Month**	**YTD**	**1 Year**	**3 Year**	**5 Year**	**10 Year**	**LOF**	**2015**	**2014**	**2013**	**Date of Inception**	**Short-term Trading Fee (% / days)**	**Exp. Ratio**	**Exp. Ratio Date**
American Funds EuroPacific Growth Fund® Class R-6	OUBE	298706821	RERGX	7.11	-2.32	-2.32	-8.26	3.62	2.78	3.83	8.67	-0.48	-2.29	20.58	04/16/1984	N/A	0.49	11/1/2015
Columbia Acorn USA Class Z	OFAU	19719980	AUSAX	7.03	-6.04	-6.04	- 11.83	4.88	6.03	4.81	9.67	-1.36	3.61	32.72	09/04/1996	N/A	1.08	5/1/2015
Columbia Pipeline Group Stock Fund	TVIN	N/A	CPGX	37.79	25.94	25.94	N/A	N/A	N/A	N/A	- 12.02	N/A	N/A	N/A	07/01/2015	N/A	0.0036	12/31/2015
FIAM Target Date 2005 Commingled Pool Class V	5188	74724X701	N/A	3.87	1.26	1.26	-1.08	3.79	3.97	N/A	3.02	-0.55	5.18	8.47	10/31/2007	N/A	0.48	9/30/2015
FIAM Target Date 2010 Commingled Pool Class V	5189	74724X859	N/A	4.43	1.04	1.04	-1.51	4.53	4.85	N/A	3.74	-0.59	5.67	11.62	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2015 Commingled Pool Class V	5190	74724X792	N/A	4.87	0.74	0.74	-1.95	4.8	5.08	N/A	3.65	-0.59	6.11	12.41	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2020 Commingled Pool Class V	5191	74724X743	N/A	5.19	0.53	0.53	-2.3	5.05	5.22	N/A	3.29	-0.61	6.29	13.76	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2025 Commingled Pool Class V	5192	74724X685	N/A	5.69	0.3	0.3	-2.59	5.74	5.8	N/A	3.64	-0.59	6.42	17.16	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2030 Commingled Pool Class V	5193	74724X636	N/A	6.46	-0.23	-0.23	-3.34	6.01	5.96	N/A	3.13	-0.69	6.66	18.82	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2035 Commingled Pool Class V	5194	74724X578	N/A	6.88	-0.53	-0.53	-3.79	6.42	6.2	N/A	3.32	-0.75	6.61	21.61	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2040 Commingled Pool Class V	5195	74724X529	N/A	6.97	-0.46	-0.46	-3.69	6.55	6.25	N/A	3.17	-0.76	6.71	21.99	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2045 Commingled Pool Class V	5196	74724X461	N/A	6.94	-0.53	-0.53	-3.75	6.65	6.35	N/A	3.23	-0.75	6.67	22.68	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2050 Commingled Pool Class V	5197	74724X412	N/A	6.96	-0.46	-0.46	-3.73	6.69	6.28	N/A	3.04	-0.77	6.69	22.75	10/31/2007	N/A	0.47	9/30/2015
FIAM Target Date 2055 Commingled Pool Class V	3585	74734B541	N/A	6.95	-0.43	-0.43	-3.69	6.86	N/A	N/A	7.14	-0.78	6.62	23.82	07/12/2011	N/A	0.48	9/30/2015
FIAM Target Date 2060 Commingled Pool Class V	3766	74734K343	N/A	6.9	-0.43	-0.43	N/A	N/A	N/A	N/A	-7.1	N/A	N/A	N/A	05/06/2015	N/A	6.87	9/30/2015
FIAM Target Date Income Commingled Pool Class V	5187	74724X206	N/A	3.01	1.48	1.48	-0.56	2.89	3.19	N/A	2.52	-0.57	4.44	5.31	10/31/2007	N/A	0.47	9/30/2015
Fidelity ® Growth Company Commingled Pool	3716	31617E836	N/A	6.88	-5.39	-5.39	-2.54	N/A	N/A	N/A	9.35	8.26	14.3	N/A	12/13/2013	N/A	0.43	9/30/2015

Fidelity® Balanced Fund - Class K	2077	316345602	FBAKX	4.94	0.09	0.09	-1.61	8.18	8.17	6.09	9.15	0.5	10.52	20.64	11/06/1986	N/A	0.46	10/30/2015
Fidelity® Contrafund® Commingled Pool	3717	31617E851	N/A	5.53	-1.38	-1.38	0.88	N/A	N/A	N/A	6.34	6.22	N/A	N/A	01/17/2014	N/A	0.43	9/30/2015
Fidelity® Equity-Income Fund - Class K	2085	316128651	FEIKX	6.8	1.9	1.9	-1.77	7.3	7.59	4.48	11.28	-3.41	8.81	27.85	05/16/1966	N/A	0.59	3/31/2016
Fidelity® Institutional Money Market - Money Market Portfolio - Class I	59	316175207	FMPXX	0.03	0.08	0.08	0.18	0.1	0.12	1.37	3.94	0.11	0.05	0.08	07/05/1985	N/A	0.21	5/28/2015
7-Day Yield* % as of 3/31/2016: 0.35 7-Day Yield Without Reductions** % as of 3/31/2016: 0.32																		
Invesco Small Cap Value Fund Class Y	OLJD	00143M497	VSMIX	11.86	-0.48	-0.48	-13.43	6.86	8.45	8.33	9.01	-8.64	7.43	44.55	06/21/1999	N/A	0.89	8/28/2015
Managed Income Portfolio Class 2	3704	31617E877	N/A	0.12	0.35	0.35	1.38	1.25	1.26	2.08	4.39	1.36	1.19	1.14	09/07/1989	N/A	0.58	9/30/2015
7-Day Yield* % as of 3/31/2016: 1.42																		
MFS® Massachusetts Investors Trust Class R5	OU28	575736814	MITJX	5.56	-0.79	-0.79	-1.54	9.99	10.37	7.12	15.01	0.58	11.36	32.35	07/15/1924	N/A	0.38	4/30/2015
NiSource Stock Fund	TRFD	N/A	N/A	9.47	21.06	21.06	38.21	29.76	29.07	16.17	10.78	19.41	31.98	35.84	11/08/2000	N/A	0.0036	12/31/2015
Northern Small Cap Value Fund	OKHE	665162400	NOSGX	8.01	2.8	2.8	-4.17	8.45	8.75	5.79	9.76	-4.62	7.07	36.44	03/31/1994	N/A	1.23	7/31/2015
Oakmark International Fund Class I	OFOI	413838202	OAKIX	8.7	-2.95	-2.95	-12.37	2.72	4.4	4.82	9.49	-3.83	-5.41	29.34	09/30/1992	N/A	0.95	1/28/2016
Perkins Small Cap Value Fund Class N	OY7B	47103D728	JDSNX	7.45	3.85	3.85	-1.82	8.39	7.18	7.58	11.75	-2.39	7.58	29.95	02/14/1985	N/A	0.56	10/28/2015
Spartan® 500 Index Fund - Institutional Class	2327	315911768	FXSIX	6.78	1.34	1.34	1.77	11.79	11.55	6.98	9.9	1.36	13.65	32.35	02/17/1988	N/A	0.05	4/29/2015
Spartan® Extended Market Index Fund - Fidelity Advantage Class	1521	315911883	FSEVX	8.2	-0.86	-0.86	-9	8.05	8.48	6.9	7.29	-3.32	7.71	38.23	11/05/1997	0.75 /90	0.07	4/29/2015
Spartan® International Index Fund - Fidelity Advantage Class	1522	315911875	FSIVX	6.52	-2.7	-2.7	-8.35	2.18	2.35	1.89	4.28	-0.79	-5.37	21.8	11/05/1997	1.00 /90	0.17	4/29/2015
Vanguard Inflation-Protected Securities Fund Institutional Shares	OSVQ	922031745	VIPIX	1.9	4.58	4.58	1.55	-0.74	3.02	4.53	4.36	-1.67	4.07	-8.83	06/29/2000	N/A	0.07	4/28/2015
Vanguard Total Bond Market Index Fund Institutional Shares	OQFC	921937504	VBTIX	0.95	3.09	3.09	1.83	2.39	3.72	4.89	5.49	0.41	5.9	-2.14	12/11/1986	N/A	0.06	4/28/2015
American Funds EuroPacific Growth Fund® Class R-6	OUBE	298706821	RERGX	7.11	-2.32	-2.32	-8.26	3.62	2.78	3.83	8.67	-0.48	-2.29	20.58	04/16/1984	N/A	0.49	11/1/2015

Primary Index

	Cumulative Total Returns % Period Ending March 31, 2016			Average Annual Total Returns % Quarter Ending March 31, 2016				Calendar Year Returns		
Index Name	**1 Month**	**3 Month**	**YTD**	**1 Year**	**3 Year**	**5 Year**	**10 Year**	**2015**	**2014**	**2013**
MSCI AC Wld ex US (N)	8.13	-0.38	-0.38	-9.19	0.32	0.31	1.94	-5.66	-3.87	15.29
Russell 2000	7.98	-1.52	-1.52	-9.76	6.84	7.2	5.26	-4.41	4.89	38.82
S&P 500	6.78	1.35	1.35	1.78	11.82	11.58	7.01	1.38	13.69	32.39
Barclays U.S. Agg Bond	0.92	3.03	3.03	1.96	2.5	3.78	4.9	0.55	5.97	-2.02
Russell 3000 Growth	6.81	0.34	0.34	1.34	13.16	12	8.09	5.09	12.44	34.23
Russell 3000 Value	7.29	1.64	1.64	-2.05	9.08	9.95	5.6	-4.13	12.7	32.69
MSCI Europe (Net MA)	6.32	-2.44	-2.44	-8.23	2.96	2.32	2.3	-2.62	-5.96	25.54
Barclays GNMA	0.26	1.75	1.75	2.4	2.35	3.28	4.85	1.39	5.97	-2.12
CG 3-Month Treasury Bill	0.02	0.05	0.05	0.08	0.05	0.06	1.07	0.03	0.03	0.05
Barclays Int Govt/Cr Bond	0.72	2.45	2.45	2.06	1.83	3.01	4.34	1.07	3.13	-0.86
MSCI EAFE (Net MA)	6.54	-2.95	-2.95	-8.12	2.38	2.43	1.95	-0.67	-4.77	22.92
MS AC Pac Fr (Net MA)	8.53	-1.62	-1.62	-9.51	0.64	1.63	2.14	-1.79	-0.88	12.6
Barclays 1-3 Gov/Cred	0.36	0.98	0.98	1.04	0.95	1.14	2.8	0.65	0.77	0.64
Barclays 3M t-bill	0.05	0.08	0.08	0.14	0.09	0.09	1.19	0.07	0.05	0.08
Russell 2000 Value	8.29	1.7	1.7	-7.72	5.73	6.67	4.42	-7.47	4.22	34.52
MSCI Wld ex US (N)	6.79	-1.95	-1.95	-8.44	1.69	1.62	1.8	-3.04	-4.32	21.02
BC US LT Treasury Index	0	8.15	8.15	2.77	6.14	9.67	7.97	-1.21	25.07	-12.66
BofA ML 1-3 Yr US Treas	0.17	0.9	0.9	0.92	0.77	0.87	2.48	0.54	0.62	0.36
DJ US Completion TSM	8.18	-0.94	-0.94	-9.14	7.93	8.37	6.79	-3.42	7.63	38.05
Barclays US TIPS	1.8	4.46	4.46	1.51	-0.71	3.02	4.62	-1.44	3.64	-8.61
Barclays Agg Float Adj	0.98	3.12	3.12	1.88	2.47	3.8	N/A	0.44	5.85	-1.97
Russell 1000 Growth	6.74	0.74	0.74	2.52	13.61	12.38	8.28	5.67	13.05	33.48

FOOTNOTES

The Bolded funds are Frozen Funds.

Fund line-up as of 04/14/2016

Last categorization update date 3/31/2016

The Columbia Pipeline Group Stock Fund was added to the Plan as a result of the July 1, 2015 corporate spin-off of Columbia Pipeline Group, Inc. from NiSource Inc. and is a frozen fund in the Plan. The Columbia Pipeline Group Stock Fund will be liquidated as of July 1, 2016.

Total returns are historical and include change in share value and reinvestment of dividends and capital gains, if any. Cumulative total returns are reported as of the period indicated. Life of Fund figures are reported as of the inception date to the period indicated. These figures do not include the effect of sales charges, if any, as these charges are waived for contributions made through your company's employee benefit plans. If sales charges were included, returns would have been lower.

Fidelity® Money Market Trust Retirement Government Money Market II Portfolio: As of December 1, 2015, the name of this fund was changed from Fidelity® Money Market Trust Retirement Money Market Portfolio.

FIAM Target Date 2005 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2005 Commingled Pool.

FIAM Target Date 2010 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2010 Commingled Pool.

FIAM Target Date 2015 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2015 Commingled Pool.

FIAM Target Date 2020 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2020 Commingled Pool.

FIAM Target Date 2025 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2025 Commingled Pool.

FIAM Target Date 2030 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2030 Commingled Pool.

FIAM Target Date 2035 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2035 Commingled Pool.

FIAM Target Date 2040 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2040 Commingled Pool.

FIAM Target Date 2045 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2045 Commingled Pool.

FIAM Target Date 2050 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2050 Commingled Pool.

FIAM Target Date 2055 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2055 Commingled Pool.

FIAM Target Date 2060 Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle 2060 Commingled Pool.

FIAM Target Date Income Commingled Pool Class V: As of February 12, 2016, this fund changed its name from Pyramis Core Lifecycle Income Commingled Pool.

MFS® Massachusetts Investors Trust Class R3, MFS® Massachusetts Investors Trust Class R4: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 04/01/2005. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 07/15/1924, adjusted to reflect the fees and

expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

American Funds EuroPacific Growth Fund® Class R-6: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 05/01/2009. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 04/16/1984, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

American Funds EuroPacific Growth Fund® Class R-5: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 05/15/2002. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 04/16/1984, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Perkins Small Cap Value Fund Class N: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 05/31/2012. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 02/14/1985, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

MFS® Massachusetts Investors Trust Class R5: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 06/01/2012. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 07/15/1924, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Vanguard Inflation-Protected Securities Fund Admiral Shares: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 06/10/2005. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 06/29/2000, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Perkins Small Cap Value Fund Class I: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 07/06/2009. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 02/14/1985, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Invesco Small Cap Value Fund Class Y: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 08/12/2005. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 06/21/1999, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Vanguard U.S Growth Fund Admiral™ Shares: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 08/13/2001. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 01/06/1959, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Vanguard Total Bond Market Index Fund Institutional Shares: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/18/1995. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 12/11/1986, adjusted to reflect the fees and expenses of this share class (when this

share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Vanguard Inflation-Protected Securities Fund Institutional Shares: Except for Life of Fund returns, the analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 12/12/2003. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 06/29/2000, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

Managed Income Portfolio Class 1, Managed Income Portfolio Class 2: Expense Ratio (Gross) includes management and wrap contract fees. For certain investments, it may also include distribution fees. Please note that the Gross and Net Expense Ratio are the same for this investment.

Fidelity® Europe Fund, Fidelity® Institutional Money Market - Money Market Portfolio - Class I, Spartan® 500 Index Fund - Institutional Class, Spartan® 500 Index Fund - Investor Class, Spartan® International Index Fund - Fidelity Advantage Class: Fidelity is voluntarily reimbursing a portion of the fund's expenses. If Fidelity had not, the returns would have been lower.

Spartan® 500 Index Fund - Institutional Class: Initial offering of the Institutional Share Class took place on May 4, 2011. Returns prior to that date are those of the Fidelity Advantage Class and reflect the Fidelity Advantage Class' expense ratio. Had the Institutional Class' expense ratio been reflected, total returns would have been higher.

Managed Income Portfolio Class 2: On February 6, 2013, an initial offering of the Managed Income Portfolio Class 2 took place. Returns and expenses prior to that date are those of the Managed Income Portfolio Class 1. Had class 2 expenses been reflected in the returns shown, total returns would have been higher.

Managed Income Portfolio Class 1, Managed Income Portfolio Class 2: Management Fee includes the costs associated with managing the investments in the pool. The management fee does not include the wrap contract fees, which are paid to third party wrap providers and do not result in any additional compensation to Fidelity. The wrap contract fees are not separately stated but are included in the Expense Ratio and do reduce returns.

Fidelity® Balanced Fund - Class K, Fidelity® Contrafund® - Class K, Fidelity® Equity-Income Fund - Class K, Fidelity® Growth & Income Portfolio - Class K, Fidelity® Growth Company Fund - Class K, Fidelity® Magellan® Fund - Class K, Fidelity® Overseas Fund - Class K: On May 9, 2008, an initial offering of the retirement (K) class took place. Returns and expenses prior to that date are those of the non-K, non-advisor class. Had K class expenses been reflected in the returns shown, total returns would have been higher.

Spartan® Extended Market Index Fund - Fidelity Advantage Class, Spartan® International Index Fund - Fidelity Advantage Class: On October 14, 2005, an initial offering of the Fidelity Advantage Share Class took place. Returns prior to that date are those of the Investor Class and reflect the Investors Class' expense ratio. Had the Fidelity Advantage Class' expense ratio been reflected, total returns would have been higher.

FIAM Target Date 2005 Commingled Pool Class V, FIAM Target Date 2010 Commingled Pool Class V, FIAM Target Date 2015 Commingled Pool Class V, FIAM Target Date 2020 Commingled Pool Class V, FIAM Target Date 2025 Commingled Pool Class V, FIAM Target Date 2030 Commingled Pool Class V, FIAM Target Date 2035 Commingled Pool Class V, FIAM Target Date 2040 Commingled Pool Class V, FIAM Target Date 2045 Commingled Pool Class V, FIAM Target Date 2050 Commingled Pool Class V, FIAM Target Date Income Commingled Pool Class V: The inception date of this V share class of the Pool was 07/01/2008. The earliest share class of this Pool had an inception date of 10/31/2007. Performance between the inception date of the earliest share class and the inception date of this V share class was calculated by subtracting Class V's management fee and the Pool's net administrative expenses for that period from the Pool's gross performance.

Columbia Pipeline Group Stock Fund, FIAM Target Date 2005 Commingled Pool Class V, FIAM Target Date 2010 Commingled Pool Class V, FIAM Target Date 2015 Commingled Pool Class V, FIAM Target Date 2020 Commingled Pool Class V, FIAM Target Date 2025 Commingled Pool Class V, FIAM Target Date 2030 Commingled Pool Class V, FIAM Target Date 2035 Commingled Pool Class V, FIAM Target Date 2040 Commingled Pool Class V, FIAM Target Date 2045 Commingled Pool Class V, FIAM Target Date 2050 Commingled Pool Class V, FIAM Target Date 2055 Commingled Pool Class V, FIAM Target Date 2060 Commingled Pool Class V, FIAM Target Date Income Commingled Pool Class V, Managed Income Portfolio Class 1, Managed Income Portfolio Class 2, NiSource Stock Fund, Fidelity ® Growth Company Commingled Pool, Fidelity® Contrafund® Commingled Pool: This investment option is not a mutual fund.

Indices are unmanaged and you cannot invest directly in an index.

Morningstar, Inc., provided data on the non-Fidelity mutual funds. Although the data is gathered from reliable sources, accuracy and completeness cannot be guaranteed by Morningstar.

*The current yield of the money market mutual fund listed above reflects the current earnings of the fund, while the total return refers to a specific past holding period.

** The yield without applicable waivers or reimbursements, whenever Fidelity is subsidizing all or a portion of the fund's expenses as of the current reporting period. Absent such waivers or reimbursements, the returns would have been lower. Waivers and/or reimbursements may be discontinued any time.

Expense Ratio Footnotes

For a mutual fund, the expense ratio is the total annual fund or class operating expenses (before waivers or reimbursements) paid by the fund and stated as a percent of the fund's total net assets. Where the investment option is not a mutual fund, the figure displayed in the expense ratio field is intended to reflect similar information. However, it may have been calculated using methodologies that differ from those used for mutual funds. Mutual fund data has been drawn from the most recent prospectus. For non-mutual fund investment options, the information has been provided by the trustee or plan sponsor. When no ratio is shown for these options it is due to the fact that none was available. Nevertheless, there may be fees and expenses associated with the investment option.

Investment Risk

Investments in mid-sized companies may involve greater risk than those of larger, more well-known companies, but may be less volatile than investments in smaller companies.

Investments in smaller companies may involve greater risk than those in larger, more well-known companies.

Foreign investments, especially those in emerging markets, involve greater risk and may offer greater potential returns than U.S. investments. This risk includes political and economic uncertainties of foreign countries, as well as the risk of currency fluctuation.

You could lose money by investing in a money market fund. Although the fund seeks to preserve the value of your investment at $1.00 per share, it cannot guarantee it will do so. An investment in the fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. The fund's sponsor has no legal obligation to provide financial support to money market funds and you should not expect that the sponsor will provide financial support to the fund at any time.

Single company stock funds are neither mutual funds nor diversified or managed investment options.

Stock markets, especially foreign markets, are volatile and can decline significantly in response to adverse issuer, political, regulatory, market or economic developments.

In general the bond market is volatile and bonds entail interest rate risk (as interest rates rise bond prices usually fall and vice versa). This effect is usually pronounced for longer-term securities. Bonds also entail the risk of issuer default, issuer credit risk and inflation risk.

Target date investments are generally designed for investors expecting to retire around the year indicated in each investment's name. The investments are managed to gradually become more conservative over time. The investment risks of each target date investment change over time as its asset allocation changes. They are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad and may be subject to risk associated with investing in high yield, small cap and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates.

Fidelity Freedom Funds are designed for investors expecting to retire around the year indicated in each fund's name. Except for the Freedom Income Fund, the funds' asset allocation strategy becomes increasingly conservative as it approaches the target date and beyond. Ultimately, they are expected to merge with the Freedom Income Fund. The investment risks of each Fidelity Freedom Fund change over time as its asset allocation changes. They are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad and may be subject to risks associated with investing in high yield, small cap and, commodity-related, foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates.

The value of your investment in a company stock fund is affected by the performance of the company and the overall stock market and, if applicable, by the amount and performance of any short-term investments held by the fund.

To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform

very well often cause another asset category, or other particular security to perform poorly. If you invest more than 20% of your retirement savings in any one company or industry, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help manage your investment risk.

Index Definitions

BC US LT Treasury Index: The Barclays Long-Term Treasury Index is an unmanaged index comprised of fixed-income securities with various maturities greater than 10 years. Unless otherwise noted, index returns reflect the reinvestment of dividends and capital gains, if any, but do not reflect fees, brokerage commissions or other expenses of investing. It is not possible to invest directly in an index.

Barclays 1-3 Gov/Cred: The Barclays 1-3 Year Government/Credit Bond Index is an unmanaged market value-weighted index for government and corporate fixed-rate debt issues with maturities between one and three years. Government and corporate issues include all public obligations of the U.S. Treasury (excluding flower bonds and foreign-targeted issues) and U.S. Government agencies, as well as nonconvertible investment-grade, SEC-registered corporate debt.

Barclays 3M t-bill: Barclays U.S. 3 Month Treasury Bellwether Index is a market value-weighted index of investment-grade fixed-rate public obligations of the U.S. Treasury with maturities of 3 months, excluding zero coupon strips.

Barclays Agg Float Adj: The Barclays U.S. Aggregate Float Adjusted Index measures the total universe of public, investment-grade, taxable, fixed income securities in the United States-including government, corporate, and international dollar-denominated bonds, as well as mortgage-backed and asset-backed securities-all with maturities of more than 1 year.

Barclays GNMA: The Barclays GNMA Index is an unmanaged market value-weighted index of fixed-rate securities issued by the Government National Mortgage Association (GNMA). These securities represent interests in pools of mortgage loans with original terms of 15 and 30 years.

Barclays Int Govt/Cr Bond: Barclays U.S. Intermediate Government/Credit Bond Index is a market value-weighted index of investment-grade fixed-rate debt securities with maturities from one up to (but not including) ten years from the U.S. Treasury, U.S. Government-Related, and U.S. Corporate Indices.

Barclays U.S. Agg Bond: The Barclays U.S. Aggregate Bond Index is an unmanaged market value-weighted index for U.S. dollar denominated investment-grade fixed-rate debt issues, including government, corporate, asset-backed, and mortgage-backed securities with maturities of at least one year.

Barclays US TIPS: The Barclays U.S. TIPS Index is an unmanaged index designed to represent securities that protect against adverse inflation and provide a minimum level of real return. To be included in this index, bonds must have cash flows linked to an inflation index, be sovereign issues denominated in U.S. currency, and have more than one year to maturity, and, as a portion of the index, total a minimum amount outstanding of 100 million U.S. dollars.

BofA ML 1-3 Yr US Treas: The Merrill Lynch 1-3 Year U.S. Treasury Index is an unmanaged market index made up of U.S. Treasury issues with maturities from one to three years

CG 3-Month Treasury Bill: The Citigroup 3-Month Treasury Bill Index is an unmanaged index designed to represent the average of T-bill rates for each of the prior three months, adjusted to a bond-equivalent basis.

DJ US Completion TSM: The Dow Jones U.S. Completion Total Stock Market Index is an unmanaged index that represents all U.S. equity issues with readily available prices, excluding components of the S&P 500.

MS AC Pac Fr (Net MA): The MSCI All Country Pacific Free Index (net MA tax) is an unmanaged market capitalization-weighted equity index of stocks traded in the five developed markets in the Pacific Region (Australia, Hong Kong, Japan, New Zealand, and Singapore) as well as the emerging markets of China, Indonesia, Korea, Malaysia, the Philippines, Taiwan, and Thailand. This index excludes those stocks that cannot be purchased by foreign investors in otherwise free markets. The index returns for periods after 10/31/2001 are adjusted for tax withholding rates applicable to U.S.-based mutual funds organized as Massachusetts business trusts.

MSCI AC Wld ex US (N): MSCI All Country World ex USA Index is a market capitalization-weighted index of stocks traded in global developed and emerging markets, excluding the United States. The Index is designed to measure equity market performance in global developed and emerging markets, excluding the United States and excludes certain market segments unavailable to U.S. based investors

MSCI EAFE (Net MA): The MSCI Europe, Australasia and Far East Index (net MA tax) is an unmanaged market capitalization-weighted index of equity securities of companies domiciled in various countries. The index is designed to represent performance of developed stock markets outside the United States and Canada and excludes certain market segments unavailable to U.S. based investors. The index returns for periods after 1/1/1997 are adjusted for tax withholding rates applicable to U.S.-based mutual funds organized as Massachusetts business trusts.

MSCI Europe (Net MA): The MSCI Europe Index is an unmanaged market capitalization-weighted index designed to represent the performance of developed stock markets in Europe.

MSCI Wld ex US (N): MSCI World ex-US Index is a market capitalization weighted index of equity securities of companies domiciled in various countries. The Index is designed to represent the performance of developed stock markets throughout the world and excludes certain market segments unavailable to U.S. based investors.

Russell 1000 Growth: The Russell 1000® Growth Index is an unmanaged market capitalization-weighted index of growth-oriented stocks of the largest U.S. domiciled companies that are included in the Russell 1000 Index. Growth-oriented stocks tend to have higher price-to-book ratios and higher forecasted growth values.

Russell 2000: The Russell 2000® Index is an unmanaged market capitalization-weighted index of 2,000 small company stocks of U.S. domiciled companies.

Russell 2000 Value: The Russell 2000® Value Index is an unmanaged market capitalization-weighted index of value-oriented stocks of U.S. domiciled companies that are included in the Russell 2000 Index. Value-oriented stocks tend to have lower price-to-book ratios and lower forecasted growth values.

Russell 3000 Growth: The Russell 3000 Growth Index is an unmanaged market capitalization-weighted index of growth-oriented stocks of U.S. domiciled companies that are included in the Russell 3000 Index. Growth-oriented stocks tend to have higher price-to-book ratios and higher forecasted growth values.

Russell 3000 Value: The Russell 3000® Value Index is an unmanaged market capitalization-weighted index of value-oriented stocks of U.S. domiciled companies that are included in the Russell 3000 Index. Value-oriented stocks tend to have lower price-to-book ratios and lower forecasted growth values.

S&P 500: S&P 500 Index is a market capitalization-weighted index of 500 common stocks chosen for market size, liquidity, and industry group representation to represent U.S. equity performance.

Before investing, consider the funds' investment objectives, risks, charges, and expenses. Contact Fidelity for a prospectus or, if available, a summary prospectus containing this information. Read it carefully.

Fidelity Brokerage Services LLC, Member NYSE, SIPC, 900 Salem Street, Smithfield, RI 02917

Important Message

The following Schedule of Benefits attachments reflect different benefit provisions for different employee groups that participate in the Plan.

PLEASE REVIEW THE FOLLOWING TABLE OF CONTENTS FOR THE ATTACHED SCHEDULES TO FIND THE SCHEDULE THAT FURTHER DESCRIBES YOUR PLAN BENEFIT PROVISIONS.

PLEASE MAKE SURE THAT YOU REFER TO THE CORRECT SCHEDULE AS ONLY ONE SCHEDULE WILL APPLY TO YOU.

These schedules are organized according to your pension benefit eligibility under a NiSource-sponsored pension plan. If you are not eligible for a NiSource-sponsored pension plan, see Schedule 1 (unless you are a Bay State Union Employee). Otherwise, see the Schedule that applies to you . If you have questions about whether you are a FAP, AB I or AB II Benefit Employee under a NiSource pension plan, please contact the Fidelity Benefits Service Center at 1-800-305-4015.

IF YOU HAVE ADDITIONAL QUESTIONS ABOUT WHICH SCHEDULE APPLIES TO YOU, PLEASE CONTACT THE NISOURCE INC. HUMAN RESOURCES DEPARTMENT FOR FURTHER CLARIFICATION AT 219-647-5571.

SPD Schedules for
NiSource Inc. Retirement Savings Plan

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SCHEDULE OF BENEFIT INFORMATION

For Eligible Employees Not Earning a Company Pension Benefit *

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. The Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

You will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer six percent (6%) of your Compensation.[†] You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus (or including, as appropriate) the following additional items: (1) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (2) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); (3) any amounts deferred to a nonqualified plan maintained by the Company (included only for calculating Elective Deferral Contributions and Matching Contributions); and (4) any amounts attributable to "banked" vacation (if applicable) that are paid to you under the NiSource Vacation Policy during the calendar year that includes your termination of employment.

Note that your "Compensation" is calculated differently for purposes of determining your Profit Sharing Contributions (described below). For this purpose, your "**Compensation**" generally means your base earnings for the calendar year, plus the following additional items: (1) all shift premiums (*e.g.*, shift differential, call-out, standby, upgrades, and temporary reclassifications/promotions) and overtime pay for the calendar year; (2) sales commissions if considered part of your "base earnings"; (3) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); and (4) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program).

Employer Contributions

As an Eligible Employee who was hired or rehired on or after January 1, 2010 and classified by the Company as an "exempt employee," or an Eligible Employee who was hired on or after January 1 2013 and classified by the Company as a "non-exempt employee," (and you are not a Bay State Union employee or NIPSCO Union employee), you are eligible for the Employer Contribution described in this paragraph. Each pay period, the Company will make an Employer Contribution in the amount of 3% of Compensation to the account of each employee eligible for this contribution. You will receive this contribution each pay period whether or not you make contributions to the Plan. All such Employer Contributions will be made to the Company Stock Fund. Once the Employer Contributions are in your Account, you may diversify them among any of the investment options available under the Plan. Your eligibility for and receipt of this Employer Contributions shall not affect your eligibility for, and shall be in addition to, the Profit Sharing Contributions described below.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of**

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees who are NOT eligible to earn a benefit under a Company Pension Plan (except for non-pension eligible union employees of Bay State Gas Company which are subject to the next Schedule). Specifically, this Schedule applies to (1) Eligible Exempt Employees hired or rehired on or after January 1, 2010, (2) Eligible Non-Union Non-Exempt Employees hired or rehired on or after January 1, 2013 and (3) Eligible Union Employees of Columbia Energy Group (or a CEG affiliate) hired or rehired on or after January 1, 2013. Other Eligible Employees who participate in the Plan should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

[†] If this Schedule applies to you and you are a Union Employee of Columbia Energy Group, your automatic contribution, unless you make a different election, will be deemed to be three percent (3%) of your Compensation until the collective bargaining agreement applicable to you provides otherwise.

Compensation. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,200, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contribution:	**1,800 ($60,000 x 3%)**
Matching Contribution:	**+ 1,800 ($3,600 x 50%)**
Total Annual Contribution:	**$7,200**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. Unless your collective bargaining agreement (if applicable) provides otherwise, you will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

SCHEDULE OF BENEFIT INFORMATION

For Eligible Bay State Union Employees Not Earning a Company Pension Benefit*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. The Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

You will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer three percent (3%) of your Compensation. However, if you are a Northampton Employee or Springfield Clerical/Technical Employee hired after January 1, 2016, you will be deemed to defer six percent (6%) of your Compensation under the automatic enrollment provisions. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus the following additional items: (1) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (2) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); (3) any amounts deferred to a nonqualified plan maintained by the Company (included only for calculating Elective Deferral Contributions and Matching Contributions); and (4) any amounts attributable to "banked" vacation (if applicable) that are paid to you under the NiSource Vacation Policy during the calendar year that includes your termination of employment.

Employer Contributions

As an Eligible Employee who was hired/rehired as (a) a Springfield Clerical/Technical Employee or a Northampton Employee on or after January 1, 2011, (b) a Brockton Operating Employee or Lawrence Employee on or after January 1, 2013, (c) a Brockton Clerical/Technical Employee on or after June 1, 2013, or (d) a Springfield Operating Employee on or after January 1, 2014, you are eligible for the Employer Contribution described in this paragraph. Each pay period, the Company will make an Employer Contribution in the amount of 3% of Compensation to the account of each employee eligible for this contribution. You will receive this contribution each pay period whether or not you make contributions to the Plan. All such Employer Contributions will be made to the Company Stock Fund. Once the Employer Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.
Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,200, as follows:

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees who are Bay State Union employees not eligible for a NiSource-sponsored pension plan. Specifically, this applies to any Eligible Employee who was hired/rehired as (a) a Springfield Clerical/Technical Employee or a Northampton employee on or after January 1, 2011, (b) a Brockton Operating Employee or Lawrence Employee on or after January 1, 2013, (c) a Brockton Clerical/Technical Employee on or after June 1, 2013, or (d) a Springfield Operating Employee on or after January 1, 2014. Other Eligible Employees who participate in the Plan should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contribution:	**1,800 ($60,000 x 3%)**
Matching Contribution:	**+ 1,800 ($3,600 x 50%)**
Total Annual Contribution:	**$7,200**

SCHEDULE OF BENEFIT INFORMATION

For Participants Under the AB II Benefit*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. The Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

You will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer six percent (6%) of your Compensation. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus the following additional items: (1) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (2) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); (3) any amounts deferred to a nonqualified plan maintained by the Company (included only for calculating Elective Deferral Contributions and Matching Contributions); and (4) any amounts attributable to "banked" vacation (if applicable) that are paid to you under the NiSource Vacation Policy during the calendar year that includes your termination of employment.

Note that your "Compensation" is calculated differently for purposes of determining your Profit Sharing Contributions (described below). For this purpose, your "**Compensation**" generally means your base earnings for the calendar year, plus the following additional items: (1) all shift premiums (*e.g.*, shift differential, call-out, standby, upgrades, and temporary reclassifications/promotions) and overtime pay for the calendar year; (2) sales commissions if considered part of your "base earnings"; (3) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); and (4) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program).

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **$1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 6% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,200, as follows:

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees (other than Bay State union employees) that participate in the AB II Benefit under the applicable pension plan sponsored by NiSource Inc. or an affiliate. Bay State union employees that participate in the AB II Benefit should refer to the Schedule applicable to their specific division or union group. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 3,600 ($3,600 x 100%)**
Total Annual Contribution:	**$7,200**

Profit Sharing Contributions

Each year, the Company, in its sole discretion, may make a Profit Sharing Contribution based on eligible Compensation for each Eligible Employee. Unless your collective bargaining agreement (if applicable) provides otherwise, you will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All Profit Sharing Contributions will be made to the Company Stock Fund. Once the Profit Sharing Contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

SCHEDULE OF BENEFIT INFORMATION

For Bay State Union Participants Under the AB II Benefit*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. The Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

You will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date unless you elect otherwise. Specifically, unless you make a different election, you will be deemed to defer three percent (3%) of your Compensation. You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus the following additional items: (1) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (2) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); (3) any amounts deferred to a nonqualified plan maintained by the Company; and (4) any amounts attributable to "banked" vacation (if applicable) that are paid to you under the NiSource Vacation Policy during the calendar year that includes your termination of employment.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **$1 for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 6% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $7,200, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 3,600 ($3,600 x 100%)**
Total Annual Contribution:	**$7,200**

Note that even though the Summary states that Company Contributions (i.e., Matching Contributions) will be initially invested in the NiSource Stock Fund, your Matching Contributions will be invested in accordance with the investment elections that you select for your Account generally. Your Matching Contributions will not be invested automatically in the NiSource Stock Fund (unless you specifically elect to invest in that fund).

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to Eligible Employees of the Brockton Clerical/Technical, Brockton Operating, Springfield Clerical/Technical and Lawrence bargaining groups that participate in the AB II Benefit under the applicable Bay State pension plan. Effective as of January 1, 2014, this Schedule also applies to Eligible Employees of the Springfield Operating bargaining group that participate in the AB II Benefit under the Bay State Union Pension Plan. In addition, effective as of April 1, 2015, this Schedule also applies to Eligible Employees of the Northampton bargaining group that participate in the AB II Benefit under the Bay State Union Pension Plan. Other Eligible Employees that participate in the AB II Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For NIPSCO Union Participants Under the AB I Benefit*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. If you were hired or re-hired on or after June 1, 2009 (or January 1, 2008, for former NIFL employees), the Plan's automatic enrollment provisions will apply to you as described below and earlier in this Summary. See "How to Enroll" and "Automatic Enrollment and Opting Out" for additional details on participating in the Plan generally.

Automatic Enrollment

If you were hired or re-hired on or after June 1, 2009 (or January 1, 2008, for former NIFL employees), you will be automatically enrolled in the Plan as of the first pay period that is 30 days from your hire date a unless you elect otherwise. If you were hired or rehired on or after January 1, 2015, unless you make a different election, you will be deemed to defer six percent (6%) of your Compensation.† You may elect not to participate in the Plan (and avoid automatic enrollment) or change the percentage of your Compensation deferral (Pre-Tax, Roth, or After-Tax Contributions). See "Automatic Enrollment and Opting Out" found earlier in this Summary for further details.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus the following additional items: (1) annual incentive payments; (2) overtime; (3) shift differential; (4) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (5) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); and (6) any amounts deferred to a nonqualified plan maintained by the Company. For purposes of calculating Company Matching Contributions, Compensation does not include overtime.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **75¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) and/or After-Tax Contribution (a combined total) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 4.5% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,300, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 2,700 ($3,600 x 75%)**
Total Annual Contribution:	**$6,300**

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to NIPSCO Union Eligible Employees (including former NIFL and Kokomo employees) who participate in the AB I Benefit under the NIPSCO Union Pension Plan. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

† For NIPSCO Union Employees hired or rehired on or after June 1, 2009 but before January 1, 2015, unless a different election was made, you were deemed to defer three percent (3%) of your Compensation.

SCHEDULE OF BENEFIT INFORMATION

For NIPSCO Union Participants Under the FAP Benefit (including former Kokomo Union Employees)*

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

With respect to NIPSCO Union employees, the Plan's automatic enrollment provisions only apply to those employees hired or re-hired on or after June 1, 2009 (or March 1, 2009 for former Kokomo employees). Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions. As stated above, see "How to Enroll" for additional details on participating in the Plan.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus the following additional items: (1) annual incentive payments; (2) overtime; (3) shift differential; (4) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (5) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); and (6) any amounts deferred to a nonqualified plan maintained by the Company.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **10¢** for each **90¢** that you contribute as an Elective Deferral Contribution (Pre-Tax or Roth). In other words, the Company makes a Matching Contribution equal to 11.1% of your Elective Deferral Contributions each pay period. Note that the Company does not match any Catch-up Contributions or After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 10% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $6,666, as follows:

Example of Matching Contributions	
Your Contributions:	**$6,000 ($60,000 x 10%)**
Employer Contributions:	**+ 666 ($6,000 x 11.1%)**
Total Annual Contribution:	**$6,666**

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to NIPSCO Union Eligible Employees (including former Kokomo employees) who participate in the FAP Benefit under the applicable pension plan sponsored by NiSource Inc. but who were NOT previously employed by NIFL immediately prior to the merger of NIFL into NIPSCO on July 1, 2011. Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

SCHEDULE OF BENEFIT INFORMATION

For NIPSCO Union Participants Under the FAP Benefit who are former NIFL Union Employees *

Eligibility and Participation

You are eligible to participate in the Plan with the first pay period (or as soon as administratively practicable thereafter) after your employment begins. See "How to Enroll" for additional details on participating in the Plan.

Automatic Enrollment

The Plan's automatic enrollment provisions only apply to employees that were hired or re-hired by NIFL on or after January 1, 2008. Accordingly, Participants under the FAP Benefit of the applicable pension plan are not subject to the Plan's automatic enrollment provisions.

Calculating your "Compensation"

Some contributions to the Plan are based on or affected by your "Compensation" from the Company. Your "**Compensation**" generally means your aggregate basic annual salary or wages and commissions paid by the Company, plus the following additional items: (1) annual incentive payments; (2) overtime; (3) shift differential; (4) effective September 1, 2009, any one-time payments in lieu of salary increases for a given year (*i.e.*, lump-sum merit pay); (5) any pre-tax contributions made to this Plan, a Company cafeteria plan, or a qualified transportation fringe benefit program (*e.g.*, a pre-tax parking program); and (6) any amounts deferred to a nonqualified plan maintained by the Company.

Company Matching Contributions

The Company makes a Matching Contribution each pay period to your Account equal to **50¢ for each $1 you contribute as an Elective Deferral Contribution (Pre-Tax or Roth) up to the first 6% of Compensation**. So, if you contribute 6% of Compensation or more to the Plan each pay period, the Company will contribute an extra amount equal to 3% of Compensation to your Account. Note that the Company does not match any Catch-up Contributions or your After-Tax Contributions.

Here's a look at how Matching Contributions work with your contributions to help your Account grow. Assume you make $60,000 a year and contribute 6% of pay each pay period to the Plan. In one year of participation, your Account would accumulate $5,400, as follows:

Example of Matching Contributions	
Your Contributions:	**$3,600 ($60,000 x 6%)**
Employer Contributions:	**+ 1,800 ($3,600 x 50%)**
Total Annual Contribution:	**$5,400**

* STOP! MAKE SURE THIS SCHEDULE APPLIES TO YOU! This Schedule applies to NIPSCO Union Eligible Employees who participate in the FAP Benefit under the applicable pension plan sponsored by NiSource Inc. and who where employees of NIFL immediately prior to its merger into NIPSCO on July 1, 2011. Other Eligible Employees that participate in the FAP Benefit should refer to a different Schedule. If you have questions about whether this Schedule applies to you, please contact the NiSource Inc. Human Resources Department for further clarification.

POLICY SUBJECT: **Vacation**

EFFECTIVE DATE: **January 1, 2004**

REVISED: **September 23, 2015**

This policy covers regular full time and part time employees of NiSource companies whose terms and conditions of employment are not covered by a collective bargaining agreement. Note that an employee's individual vacation hours cannot be donated to another employee.

Vacation Year
The vacation year runs from January 1 through December 31 of each year.

Vacation Calculation
Vacation is granted on January 1 and is calculated based upon full years of service on the preceding December 31 (note the exception under New Hire and Rehired Employees). If service has been broken, the service date established upon return to employment will be used to calculate the vacation grant utilizing the vacation schedule in effect at time of rehire. Prior service as an intern, summer, or temporary employee will not count towards vacation eligibility.

In order to receive the annual grant, employees on short term or long term disability or any other type of leave of absence or non-work status must return to work at least one day in a new year.

New Hire and Rehired Employees
A new or rehired employee in the initial year of employment is granted vacation based on a proration of 3 weeks (120 hours) of vacation unless a rehired employee's eligible previous service makes the granted vacation 4 weeks (160 hours).

The proration is calculated based on the remaining full months in a calendar year beginning with the month after hire date month. For example:

> -Employee hired April 1, 2014; first year 2014 vacation entitlement would be 8/12 (May-Dec) x 120 hours = 80 hours taken with supervisor approval or remaining can be carried over subject to carryover limits. Beginning January 1, 2015, employee would be entitled to 3 weeks (120 hours) vacation (if applicable could be 160 hours for rehired employees depending on previous service and break-in-service).

NOTE: Any exceptions to these new hire and rehire provisions must be approved by the Sr. VP Human Resources.

2013 New or Rehired Employees
If an employee was hired or rehired in 2013, they will be granted on 1/1/14 either 3 weeks (120 hours) or 4 weeks (160 hours) depending on eligibility minus any borrowed hours used in 2013.

General Provisions

1. Vacation will be scheduled according to requirements established at the Company or Department level.
2. Vacation will be paid at the employee's regular base rate of pay, exclusive of any premium or temporary upgraded rate at the time the vacation is taken.
3. Employees are required to use 80 hours of their vacation grant per year or forfeit the difference between the number of hours used and 80 hours (exception would be in the first year of hire or rehire if vacation grant is less than 80 hours). However, if extenuating circumstances exist that are beyond the employee's control, an employee, with approvals from the employee's supervisor and the next level of management, may elect to carry over or to bank such unused vacation hours that would otherwise be subject to forfeiture.
4. After using 80 hours of their vacation grant, employees may elect to carry over up to 80 hours of unused vacation into the following year without supervisor approval. If extenuating circumstances exist that are beyond the employee's control, an employee, with approvals from the employee's supervisor and the next level of management, may elect to carry over more than 80 hours of unused vacation into the following year.
5. If no timely election has been made to carry over or to bank unused vacation hours, an employee will be deemed to have elected to carry over up to 80 unused vacation hours (assuming the employee has first used 80 hours of vacation) to the following year.
6. Any employee election referred to in this policy (other than the deemed election described immediately above) must be made in writing or electronically within the timeframes and in the manner prescribed by NiSource.

Vacation Banking

Employees age 45 and older ("qualified employees") are qualified to participate in the vacation banking program. After using 80 hours of their vacation grant, such employees may elect to bank up to 160 hours of unused vacation per year, up to a lifetime banking limit of 640 hours, during the annual vacation banking event.

If a qualified employee has not made an election to bank unused vacation hours or to carry over all such hours to the following year, such employee will be deemed to have elected first to carry over up to 80 unused vacation hours to the following year (assuming the employee has first used 80 hours of vacation), and then to have elected to bank up to 160 of any remaining unused vacation hours, subject to the lifetime banking limit.

At retirement or separation, qualified employees can bank unused vacation and floating holidays, subject to the annual limit of 160 hours and lifetime banking limit of 640 hours. Accrued vacation is not eligible for banking.

At retirement or separation, qualified employees will receive a lump-sum cash payment for their banked hours, calculated at their pay rate at the time they leave. They will have the option to defer part of the payment into their 401(k) plan based on their current deferral election on file with the 401K administrator, within IRS limits, and receive the eligible company match. In addition, the payment will count as additional eligible earnings toward retirees' final average pay or account balance pension calculations, if applicable.

Under the provisions of the federal Family and Medical Leave Act, qualified employees can “un-bank” and use banked vacation hours after they have depleted their available unused vacation and floating holiday hours for the year.

Vacation and Other Types of Leave

1. An employee will not be permitted to take vacation while receiving Worker’s Compensation payments.
2. Vacation taken as a result of one of the conditions covered under the Family and Medical Leave Act (FMLA) will count toward the twelve-week FMLA maximum leave allowance.
3. Employees on reduced-pay or no-pay sick leave/short-term disability may request vacation paid in lieu to supplement sick pay.
4. Employees will not receive credit for vacation accrued while on long-term disability, workers compensation or a Leave of Absence unless they return to work full time within one year.
5. Vacation for employees entering Military Service is covered in the Military Leave of Absence Policy.

Vacation Paid at Long Term Disability

Accrued, Unused and Banked vacation will be paid to employees at the beginning of long-term disability or at the end of the year in which the employee began long-term disability. Payment will be calculated on the basis of 1/12 of the vacation eligibility for each completed month of service. The accrual rate will be based on full years of service at the time of Long Term Disability.

Vacation Paid at Separation

Unused and banked vacation will be paid to employees at separation.

Accrued vacation will be paid to employees at separation due to involuntary severance, retirement, or death. Payment will be calculated on the basis of 1/12 of the vacation eligibility for each completed month of service in the final year of employment. The accrual rate will be based on full years of service at the end of the year of separation.

An employee will be disqualified from the right to receive unused and banked vacation pay under the Policy for the following reasons:

- An employee does not return all company property.
- An employee owes an outstanding debt to the Company at time of separation.

Vacation Schedules – Exempt and Non Exempt employees prior to January 1, 2004

Existing employees on December 31, 2003 will be grandfathered to the vacation schedule in which they were enrolled on that date. Vacation schedules can be obtained from their Human Resource Consultant or the Human Resource Delivery Team.

Vacation Schedule – Exempt and Non-Exempt employees hired or rehired on or after January 1, 2004*

All Exempt employees hired or rehire between 01/01/04 and 12/31/09 and all Non Exempt employees hired between 1/1/04 and 12/31/12 will be covered by the following vacation schedule:

Full Years of Service at 12/31/XX	Vacation Hours Granted the Following Vacation Year
1	80
3	120
10	160

*This schedule also applies for nonexempt employees in CEG benefit plans who were hired or rehired between January 1, 2000 and December 31, 2012. Also, this schedule also applies to Exempt employees in CEG benefit plans who were hired or rehired between January 1, 2000 and December 31, 2009.

Vacation Schedule – Exempt Employees hired or rehired on or after January 1, 2010 and Non Exempt hired on or rehired after January 1, 2013
All Exempt employees hired or rehired on or after 01/01/10 and Non Exempt employees hired or rehired on or after January 1, 2013 will be covered by the following vacation schedule:

Full Years of Service at 12/31/XX	Vacation Hours Granted the Following Vacation Year
January 1 after initial year of hire*	120
4	160

*If applicable could be 160 hours for rehired employees depending on previous service and break-in-service.

Exempt employees hired or rehired on or after January 1, 2010 and Non Exempt employees hired or rehired on or after January 1, 2013 will receive an additional five “bonus” days of vacation only during the succeeding year after every five-year service anniversary.

For example, after completing five full years of service, an employee will receive five extra vacation days during the following calendar year (which means a total of 25 vacation days).

The following year, the employee’s vacation level reverts back to the normal 20 days.

Non Exempt to Exempt Transfers
Non Exempt employees hired or rehired on or after January 1, 2010 and before January 1, 2013 who transfer to an Exempt position will be granted additional vacation hours (if applicable) January 1 of the following year.

Exempt or Nonexempt to Union Transfers
These transferred employees will be under the applicable union vacation schedule upon the date of transfer.

Union to Exempt or Non Exempt Transfers

These transferred employees will maintain applicable union vacation grant for the remainder of the year of transfer and then effective January 1 of the following year they will be under this nonunion vacation policy.

Vacation Schedule – Part-Time and Phased Retirement Employees
Part-time employees will be covered by one of the above schedules based on employment status and vacation plan participation as of hire date. Their annual vacation grant will be pro-rated based on the number of normal hours worked in a week.

Hours granted based on weekly schedule of normal hours worked:

30 - 39 hours per week- 85% of annual grant
20 - 29 hours per week- 65% of annual grant
15 - 19 hours per week- 45% of annual grant
14 or less hours per week- 25% of annual grant

New Hire and Rehired Part-Time Employees
A new or rehired part-time employee in the initial year of employment is granted vacation based on a proration of 3 weeks (120 hours) of vacation unless a rehired employee's eligible previous service makes the granted vacation 4 weeks (160 hours).

The proration is calculated based on the remaining full months in a calendar year beginning with the month after hire date month and the percent of annual grant above. For example:

-Part-time employee hired April 1, 2014; first year vacation entitlement would be 8/12 (May-Dec) x 120 hours x 65% = 52 hours taken with supervisor approval or remaining can be carried over subject to carryover limits. Beginning January 1, 2015, employee would be entitled to 3 weeks (120 hours) pro-rated vacation based on their weekly schedule above.

NOTE: Any exceptions to these new hire and rehire provisions must be approved by the Sr. VP Human Resources.

Mid-Year Full-Time to Part-Time Employee Change
Employees entitled to remaining full time grant in year of change. Beginning January 1 of the year following the change part-time vacation determined by annual grant percentage above.

Mid-Year Part-Time to Full-Time Employee Change
Part-time and Full time months prorated based on month of change. Examples:

-Change effective March 1 and no vacation taken for that year as of change date.

9/12 (Apr-Dec) x 120 hours = 90 hours plus part-time annual grant 102 hours (85% of 120 hours) x 3/12 (Jan-Mar) = 26 hours so employee entitled to 116 hours (90 + 26) after change for that calendar year.

-Change effective March 1 and vacation used for that year as of change date.

9/12 (Apr-Dec) x 120 hours = 90 hours plus part-time annual grant 102 hours (85% of 120 hours) x 3/12 (Jan-Mar) = 20 hours minus 15 hours taken as of change date so employee entitled to 95 hours (90 + 20 -15) after change for that calendar year.

Plan Changes

Exempt employees current pay 30% of the plan cost and Union and Non-Exempt Non-Union employees currently pay 25% of the plan cost. These percentages have not changed in past three years as they are determined to be adequately priced.

2013 Deductible

- **PPO Deductible will apply to all services except Preventive/Wellness benefits and office visits**

Annual Network Deductible 2013

- You Only—$300 to $400
- You + Spouse—$600 to $800
- You + Child(ren)—$600 to $800
- You + Family—$900 to $1,200

Annual Network Deductible 2015

- You Only—$400 to $500
- You + Spouse—$800 to $1,000
- You + Child(ren)—$800 to $1,000
- You + Family—$1,200 to $1,500

Benefit Copays 2013

- Physician Office Visit—$20 to $30
- Specialist Office Visit—$20 to $35
- Emergency Room—$0 to $100
- Hospital—80% prior to plan deductible to 80% after plan deductible

Benefit Copays 2015

- Physician Office Visit—$30 to $35
- Specialist Office Visit—$35 to $40
- Emergency Room—$100 to $150
- Hospital—80% after plan deductible
  (no change from 2013)

Prescription Copays 2013

- Mail Order 90-day Supply
  - Generic Copay—$10 to $15
  - Formulary Brand Copay—$30 to $40
  - Non-Formulary Brand Copay—$60 to $90

Prescription Copays 2015

- Mail Order 90-day Supply
  - Generic Copay—$15 to $20
  - Formulary Brand Copay—$40 to $60
  - Non-Formulary Brand Copay—$90 to $120

NISOURCE
SHORT-TERM DISABILITY PLAN

As Amended and Restated
Effective as of January 1, 2015

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ARTICLE I
INTRODUCTION

Columbia Energy Group established and maintained the Columbia Energy Group Sick Leave Plan to provide short-term disability benefits for the participants and beneficiaries thereunder. Effective as of the Plan Effective Date, the Columbia Energy Group Sick Leave Plan was broadened to include coverage for the former participants of one or more short-term disability plans sponsored by NiSource Inc. (the "Company") or an affiliate, was renamed the NiSource Short-Term Disability Plan (the "Plan"), and from such date forward, has been sponsored and maintained by the Company. The Plan was amended from time to time after the Plan Effective Date and was amended and restated effective as of August 14, 2012. This is an amendment and restatement of the Plan effective as of January 1, 2015.

ARTICLE II
DEFINITIONS

2.01 Actively at Work. "Actively at Work" means, for each day that is one of the Employer's scheduled work days, the Employee performs all of the regular duties of his job for such day. An Employee will be deemed to be Actively at Work on any day that is not one of the Employer's scheduled work days only if he was considered Actively at Work on the preceding scheduled work day.

2.02 Claims Administrator. "Claims Administrator" means the person, persons or entity appointed by the Plan Administrator pursuant to Section 8.05.

2.03 Code. "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.04 Committee. "Committee" means the NiSource Benefits Committee.

2.05 Company. "Company" means NiSource Inc., a Delaware corporation.

2.06 Disability. "Disability" means Total Disability or Partial Disability.

2.07 Disability Management Program. "Disability Management Program" means the program described in Section 5.06 below.

2.08 Employee. "Employee" means a regular, Full-time employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.09 Employer. "Employer" means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that an employee welfare benefit plan providing short-term disability benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related

Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations.

2.10 **ERISA**. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.11 **NIPSCO**. "NIPSCO" means Northern Indiana Public Service Company.

2.12 **Other Income Benefits**. "Other Income Benefits" means the amount of any benefit for loss of income, provided to a Participant, as a result of the period of Disability for which benefits are paid under the Plan. This includes any such benefits for which the Participant is eligible, or that are paid to the Participant, or to a third party on his or her behalf. This includes, but is not limited to, the amount of any benefit for loss of income for the same Disability from: (1) the United States Social Security Act, the Railroad Retirement Act, the Jones Act, or similar plan or act that the Participant is eligible to receive because of his or her Disability; (2) the Veteran's Administration or any other foreign or domestic governmental agency for the same Disability; (3) any governmental law or program that provides disability or unemployment benefits as a result of the Participant's employment with an Employer, including any state disability program; (4) any temporary or permanent disability benefits under a Workers' Compensation law, occupational disease law, or similar law; and (5) compulsory "no-fault" automobile insurance.

2.13 **Other Party**. "Other Party" includes, without limitation, any of the following:

(a) Any party or parties who caused a Disability;

(b) Any insurer or other indemnifier of the party or parties who caused a Disability;

(c) Any guarantor of the party or parties who caused a Disability;

(d) A Participant's insurer;

(e) A Workers' Compensation insurer; or

(f) Any other person, entity, policy or plan that is liable or legally responsible in relation to a Participant's Disability.

2.14 **Partial Disability**. "Partial Disability" means a Participant's mental or physical inability to perform the essential functions of his or her own occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience, on a full-time basis. The loss of any professional license or certification required for a Participant's occupation does not, in and of itself, constitute a 'Partial Disability.'

2.15 **Participant**. "Participant" means each Employee who is covered under the Plan.

2.16 Pay. "Pay" means basic earnings inclusive of sales commissions plus any before tax deposits deferred by an Employee pursuant to any qualified retirement plan sponsored by the Company or an affiliate, or any successor plans thereto, but not including overtime, shift differentials, bonus or any other form of special compensation. For employees receiving sales commissions, "Pay" shall mean the average hourly wage based on the 12 consecutive calendar months immediately preceding the last day Actively at Work.

2.17 Physician. "Physician" 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. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Physicians when acting within the scope of their license. A person who has a doctoral degree in psychology (Ph.D or Psy.D) and whose primary practice is treating patients shall also be deemed to be a Physician. A Physician shall not include any relative of a Participant, including without limitation a Participant's spouse, child, brother, sister or parent.

2.18 Plan. "Plan" means the NiSource Short-Term Disability Plan set forth herein, together with any and all amendments and supplements thereto.

2.19 Plan Administrator. "Plan Administrator" means the Committee and any persons or entities to whom the Committee has from time to time delegated authority to carry out the administrative functions of the Plan. The Committee has delegated to the Manager, HR Benefits, the Director Corporate Insurance and the Vice President Human Resources the authority to decide appeals of denied claims on behalf of the Plan Administrator pursuant to Sections 9.06 and 9.07. Such appeals shall be decided by the Manager, HR Benefits and the Director Corporate Insurance. In the event such persons do not agree on the decision with respect to an appeal, the Vice President Human Resources shall decide such appeal.

2.20 Plan Effective Date. "Plan Effective Date" means January 1, 2004.

2.21 Plan Year. "Plan Year" means the calendar year.

2.22 Related Employer. "Related Employer" means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company, (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company, and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.23 Represented Employee. "Represented Employee" means an Employee who is covered by a collective bargaining agreement between an Employer and a union.

2.24 Total Disability. "Total Disability" means a Participant's mental or physical inability to perform the essential functions of his or her own occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience. The loss of any professional license or certification required for a Participant's occupation does not, in and of itself, constitute a 'Total Disability.'

2.25 Years of Service. "Years of Service" means a Participant's 12-month period of employment with an Employer, determined as follows: a Participant's first Year of Service is counted from the Participant's date of hire to his or her first anniversary with an Employer. After the Participant's first anniversary with an Employer, Years of Service are calculated on a calendar year basis.

Thus, on the December 31 following a Participant's first anniversary with an Employer, and on each subsequent December 31 thereafter, a Participant will be credited with an additional Year of Service. For Participants who are rehired, Years of Service will be calculated based on the most recent hire date. A Participant must be Actively at Work at least one day in a calendar year to be credited with an additional Year of Service for that year under the Plan.

2.26 **Construction**. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

ARTICLE III
PARTICIPATION

Each regular, Full-time Employee of an Employer, other than a NIPSCO Represented Employee, will be covered under the Plan on the first day of the month coincident with or next following his or her completion of 6 continuous months of active, Full-time employment with an Employer. A "Full-time Employee" is an Employee characterized by an Employer as a full-time employee who regularly works 40 hours per week. For new hires, such Employee must be Actively at Work on the date coverage is scheduled to begin.

ARTICLE IV
CONTRIBUTIONS TO THE PLAN

4.01 **Participant Contributions**. As a condition of participation, a Participant shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company.

4.02 **Employer Contributions**. The Employer will contribute to the cost of the Plan to the extent such cost exceeds the amount contributed by the Participant.

ARTICLE V
PLAN BENEFITS

5.01 **Amount of Total Disability Benefits**. A Participant shall be entitled to a weekly benefit for the first 26 weeks of Total Disability based on his or her Pay and Years of Service as of the January 1st immediately prior to the date of Total Disability (except in the case of an Employee with more than six months and less than one Year of Service, in which case Pay and Years of Service shall be determined as of the date of Disability), in accordance with the following schedule:

Years of Service	Weeks of Total Disability benefit paid at 100 percent Pay	Weeks of Total Disability benefit paid at 60 percent Pay
More than 6 months (0.5 years) but less than 1 year from date of hire	1 week	0 weeks
1 year to 9 years	8 weeks	18 weeks
10 years to 19 years	16 weeks	10 weeks
20 years or more	26 weeks	0 weeks

The amount of benefit determined on a weekly basis shall be paid on a basis consistent with the Employer's payroll periods. In no instance will the benefit under the Plan extend beyond the Participant's normal retirement date as defined in any qualified retirement plan sponsored by the

Company or an affiliate, or any successor plan, or the date benefits commence under the NiSource Long-Term Disability Plan.

If a Participant is receiving weekly benefits on account of a Total Disability as of the end of a calendar year and is unable to return to work as of the beginning of the next calendar year, such Participant will continue to be entitled to the weekly benefits under the Plan to which he or she was otherwise entitled for the previous calendar year, subject to the other terms, conditions and limitations of the Plan. Subject to Section 5.04 below, such Participant will not be entitled to additional weekly benefits under the Plan until he or she returns to work for one full day in the next calendar year.

5.02 Amount of Partial Disability Benefits. A Participant shall be entitled to a weekly benefit, paid on a basis consistent with the Employer's payroll periods, for the first 26 weeks of Partial Disability based on a percentage of his or her Total Disability benefit (described in Section 5.01). The percentage of the Total Disability benefit for which a Participant shall be entitled under this Section shall equal 100 percent of his or her Total Disability benefit minus the percentage of Pay the Participant actually receives from an Employer for the performance of his or her own occupation during that period, determined on a weekly basis. If a Participant is Partially Disabled, he or she may be assigned temporary modified work, which assignment must be approved by the Participant's personal Physician, a Physician appointed by the Company (where appropriate) and the Participant's supervisor.

5.03 Commencement of Disability Benefits.

(a) Submission of Claim. The Participant must apply to the Claims Administrator, in the manner determined by the Plan Administrator and the Participant's supervisor, to commence benefit payments under the Plan. The Participant shall provide, or cause to be provided, such proof of Disability as is required by the Claims Administrator in accordance with written procedures which shall be incorporated herein by this reference. Without limiting the generality of the foregoing, if a Participant is absent from work for more than four consecutive days, the Participant must be under the regular care of a Physician and must furnish proof of Disability to the Claims Administrator.

(b) Commencement of Benefits. Upon approval by the Claims Administrator of the Participant's claim, benefits payable pursuant to this Article V shall commence on the first calendar day of the Participant's absence due to Disability, measured from the last day he or she is Actively at Work.

5.04 Recurring or Separate Periods of Disability. If a Participant is collecting Plan benefits due to a Disability, temporarily recovers and returns to work for an Employer for 180 consecutive calendar days or less, and then again incurs a Disability due to the same or a related illness or injury, the Participant's subsequent Disability is considered a recurring Disability. In such case, the Participant will be entitled to benefits for the recurring Disability for the maximum benefit period under the Plan, less the benefits the Participant has already received for that Disability.

If a Participant is collecting Plan benefits due to a Disability, temporarily recovers and returns to work for an Employer for 181 or more consecutive calendar days, and then again incurs a Disability due to the same or a related illness or injury, the Disability is considered a separate Disability. In such case, the Participant will be entitled to benefits for the separate Disability for the maximum benefit period and such amount will not be reduced by the benefits the Participant has already received for that Disability. Provided, however, that a Participant will not be entitled

to benefits under the Plan during a calendar year in excess of the benefits applicable to such Participant described in Section 5.01 above.

5.05 Coordination with Other Income Benefits. A Participant may be eligible for Other Income Benefits with respect to the period of time for which benefits are payable under the Plan. In such case, benefits under the Plan shall be fully offset by such Other Income Benefits. If a Participant is paid Other Income Benefits in a 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.

5.06 Disability Management Program.

(a) General. As a condition of receiving benefits under the Plan, a Participant must participate in, and comply with all requirements of, the Disability Management Program. The Disability Management Program certifies that a Participant qualifies for benefits under the Plan beyond the fourth day of absence from work and develops a return to work plan in consultation with the Participant and his or her Physician and supervisor.

(b) Program Requirements. As a part of the Disability Management Program, each Participant must

(i) supply the authorization and documentation described in Section 5.06(c);

(ii) maintain contact with the Claims Administrator;

(iii) follow the medical treatment plan agreed to by the Claims Administrator and the Participant's Physician; and

(iv) return to work at the time that is agreed to by the Participant, the Claims Administrator, the Participant's and the Participant's supervisor.

(c) Required Authorization and Documentation. Each Participant must provide all information requested by the Claims Administrator, including without limitation the following:

(i) a signed authorization form for the Claims Administrator to obtain all reasonably necessary medical, financial, or other non-medical information that supports the Participant's Disability claim;

(ii) proof that the Participant has applied for other sources of disability income (e.g., Workers' Compensation, State Disability Benefits, or Social Security Disability Benefits, when applicable); and

(iii) Written notification when the Participant receives or is awarded a benefit from another source of disability income, which notice shall include the following information:

(A) the type of income benefit;

(B) the amount the Participant is receiving;

(C) the period for which the benefit applies; and

(D) the duration for which the benefit is being paid (if the Participant is receiving installment payments).

(d) Release in Connection with Return to Work. Upon request, the Participant shall furnish to the Company and to the Claims Administrator a release from the Participant's Physician, satisfactory to the Company and to the Claims Administrator, as a condition of returning to work after a Disability.

5.07 Payment of Benefits. All benefits shall be paid directly to the Participant, or if the Participant is deceased, in accordance with Section 5.09. Benefits may be paid directly from the general assets of the Company or from any other lawful funding vehicle as may be established by the Company.

5.08 Duration of Benefit Payments. This Plan provides benefits for a maximum of 26 weeks during a period of Disability. Subject to Section 5.03, the duration of benefit payments is measured from the last day the Participant is Actively at Work.

Benefit payments shall terminate prior to the conclusion of 26 weeks if the Participant's Disability ends. Benefit payments shall also terminate if any of the following events occur, as determined by the Plan Administrator or the Claims Administrator:

(a) Failure to Provide Required Information. The Participant fails to submit evidence of Disability or such other documents that the Plan Administrator or Claims Administrator deems necessary to administer the Plan, in accordance with written procedures that shall be incorporated herein by this reference.

(b) Failure to Submit Evidence or Refusal of Examination. The Participant does not submit or cause to be submitted on his or her behalf evidence of continuing Disability that has been requested or the Participant refused an independent medical examination or other examinations or tests requested by the Plan Administrator or the Claims Administrator to determine whether the Participant has a continuing Disability.

(c) Other Occupation. The Participant is engaged in any other occupation or earns any self-employment income in excess of a de minimis amount.

(d) Failure to Comply with Physician's Requirements. The Participant is not under the regular care of a Physician as required by his or her condition or the Participant is not following the Physician's treatment plan.

(e) Failure to Perform Temporary Modified Work Assignment. In the case of a Partial Disability, the Participant fails or refuses to perform any temporary modified work assignment.

(f) Failure to Comply with Disability Management Program Requirements. The Participant fails to participate in or comply with all requirements of the Disability Management Program, including without limitation providing all required documentation regarding the Participant's Disability.

(g) Participant in a Felony. The Participant participates in and is convicted of a felony offense. In such case, the Participant's Disability shall be determined to have ceased as of the date that the Participant first participated in such felony offense.

(h) Fraud. The Participant commits or partakes in any actions of fraud against the Plan, an Employer, or the Committee.

(i) Termination of Employment. The Participant has been terminated or voluntarily terminates employment with the Employer (other than transfer to a Related Employer), or dies.

(j) Termination of Participant. The Participant's participation in the Plan terminates pursuant to Section 10.01.

5.09 Designation of Beneficiaries. If a Participant dies before he or she receives all of the benefits he or she is entitled to under the Plan, the Plan Administrator shall pay such benefits to the Participant's spouse, or if no spouse is living, to his or her beneficiary under any life insurance plan (as selected by the Plan Administrator) sponsored by the Company or an affiliate, or if none, to the legal representative of the estate of the Participant, or if none is appointed within 6 months after the date of his or her death, to his or her heirs under the laws of the state in which he or she is domiciled at the date of his or her death.

5.10 Facility of Payment. When a person entitled to benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the Plan.

ARTICLE VI
GENERAL EXCLUSIONS

Notwithstanding any other Plan provision to the contrary, in no event shall benefits be payable under the Plan with respect to the following categories of Disability of a Participant:

(a) Disability not being treated by a Physician;

(b) Disability caused or contributed to by war or an act of war (declared or not);

(c) Disability caused by the Participant's commission of or attempt to commit a crime for which the Participant has been convicted, or to which a contributing cause was the Participant's being engaged in an illegal occupation;

(d) Disability caused or contributed to by an intentionally self-inflicted injury; and

(e) Disability incurred while the Participant is on a leave of absence, furlough, suspension from work, or in a status other than that of Actively at Work. In such case, benefits will only commence on the date the Participant was expected to return to an Actively at Work status provide the Participant is still disabled.

ARTICLE VII
SUBROGATION

7.01 Subrogation. If an Other Party is liable or legally responsible to pay expenses, compensation and/or damages in relation to a Disability incurred by any Participant, and benefits are payable under the Plan in relation to such Disability, the Plan shall be subrogated to all rights of recovery of such Participant. The Participant or his or her legal representative shall transfer to the Plan any rights he or she may have to take legal action arising from the Disability so that the Plan may recover any sums paid on behalf of the Participant. If the Participant fails to take legal action against an Other Party, and the Plan elects to take such legal action against such Other Party, in addition to the right to recover Plan benefits paid, the Plan shall be entitled to all expenses, including reasonable attorney's fees, incurred for such recovery. If the Plan recovers an amount greater than Plan benefits paid, the excess, reduced by the expenses of recovery, including reasonable attorney's fees, shall be paid to the Participant. The Plan shall have the right, with prior notice to, but without the consent of, the Participant, to compromise the amount of its claim if, in the opinion of the Plan Administrator, it is appropriate to do so.

7.02 Right of Recovery. The Plan may recover from a Participant or his or her legal representative the amount of any benefits paid under the Plan from any payment the Participant receives or is entitled to receive from an Other Party. The Plan shall not be responsible for any attorney's fees associated with any payment received by a Participant, unless the Plan expressly assumes such obligation prior to the Participant's recovery. Accordingly, unless the Plan expressly agrees otherwise, its recovery shall not be offset by any attorney's fees incurred by a Participant.

7.03 Cooperation Required. The Participant or his or her legal representative shall cooperate fully with the Plan in asserting its subrogation and recovery rights. The Participant or his or her legal representative shall, upon request from the Plan, provide all information and sign and return all documents necessary for the Plan to exercise its rights under this provision. No Participant shall take any action to prejudice the Plan's subrogation rights.

7.04 First Lien Created. The Company shall have a first lien upon any recovery, whether by settlement, judgment, mediation, arbitration or any other means, that the Participant receives or is entitled to receive from any Other Party. Such lien shall not exceed the lesser of:

(a) the amount of benefits paid by the Plan for the Participant, plus the amount of all future benefits that may become payable under the Plan that result from the Disability. The Plan shall have the right to offset or recover such future benefits from the amount received from the Other Party; or

(b) the amount recovered from the Other Party.

The Company's first lien rights will not be reduced (1) due to the Participant's own negligence, (2) due to the Participant not being made whole, or (3) due to any attorney's fees and costs incurred by the Participant.

7.05 Personal Liability Created. If a Participant or his or her legal representative makes any recovery from any Other Party and fails to reimburse the Plan for any benefits paid as a result of the Disability, then (1) the Participant or his or her legal representative shall be personally liable to the Plan for the amount of the benefits paid under the Plan, and (2) the Plan may reduce future benefits payable by the amount of payment that the Participant or his or her legal representative has received from the Other Party. If the Plan institutes legal action against a Participant who fails to reimburse the Plan as required by this Section, in addition to liability to the Plan for the

amount of benefits paid under the Plan, such Participant shall be liable to the Plan for the amount of the Plan's costs of collection, including reasonable attorney's fees.

ARTICLE VIII
ADMINISTRATION OF PLAN

8.01 Company to Administer the Plan. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA.

8.02 The Committee. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

8.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Participants;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Plan;

(h) To determine the status and rights of all Participants;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Plan;

(k) To obtain from the Company, Participants and others, such information as is necessary for the proper administration of the Plan;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

8.04 Interpretative Authority. The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Summary Plan Description thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

8.05 Appointment of the Claims Administrator. The Plan Administrator shall appoint a Claims Administrator to provide administrative services to the Plan Administrator in connection with the operation of the Plan and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons or entity serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

ARTICLE IX
CLAIMS FOR BENEFITS

9.01 Filing Initial Claim. The entity designated by the Company (the "Claims Administrator") shall process benefit claims pursuant to the procedures set forth below.

9.02 Consideration of Initial Claim. The Claims Administrator shall provide notice to a claimant of its decision regarding his or her claim within a reasonable period of time, but generally not later than 45 days after receipt of the claim by the Plan. This 45-day period may be extended for up to 30 days if the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time 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 that the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a Disability benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information, if any.

9.03 If the Claims Administrator Denies the Initial Claim. If the Claims Administrator denies a claim for a Disability benefit in whole or in part, it shall provide the claimant with a written notice of the denial stating (i) the specific reason or reasons for the denial; (ii) reference to the specific Plan provisions on which the denial is based; (iii) 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 (iv) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

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 the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

9.04 Appeal to the Claims Administrator. If the Claims Administrator denies a claimant's Disability claim in whole or in part, the claimant has the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of his or her receipt of the claim denial notification.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant will be provided free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks his or her claim should not have been denied. The letter must include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on his or her claim.

Upon receipt of a claim, the Claim Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the 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 individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

The Claims Administrator will notify a claimant of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of a claimant's 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 the claimant 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.

9.05 If the Claims Administrator Denies the Claim on Appeal. If the Claims Administrator denies all or any portion of a claim on appeal, it will notify the claimant in a manner calculated to be understood by the claimant of (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) 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; and (iv) a statement indicating the claimant's right to file a lawsuit upon completion of the claims procedure 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 the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

9.06 Appeal to the Plan Administrator. If the Claim Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Plan Administrator, by sending a written request for review to the Plan Administrator within 45 days of the claimant's receipt of the Claim Administrator's claim denial notification.

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

A claimant's written appeal should state why he or she thinks the claim should not have been denied. The letter must include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the appeal to the Claim Administrator. The review will not afford deference to the Claim Administrator's decision.

The Plan Administrator will notify a claimant of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of a claimant's 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 the claimant 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 expects to render the determination on review.

9.07 If the Plan Administrator Denies the Claim on Appeal. If the Plan Administrator denies a claim on appeal, it will notify the claimant in a manner calculated to be understood by the claimant of (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) 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; and (iv) a statement indicating the claimant's right to file a lawsuit upon completion of the claims procedure 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 the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

9.08 Legal Actions. No legal action may be brought against the Plan until the claimant has exhausted all claims and appeals to the Claims Administrator and the Plan Administrator. No such action may be brought after three years from the time a claim should have been filed.

9.09 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.

9.10 Construction of Article. This Article IX shall be construed in a manner consistent with Department of Labor Regulations governing claims procedures applicable to disability benefit plans.

ARTICLE X
TERMINATION OF PARTICIPATION

10.01 Cessation of Participation. Except as otherwise provided in this Article X, a Participant shall cease to participate in the Plan on the earliest of the following dates:

(i) The date as of which the Plan is terminated;

(ii) The date that the Plan is amended to terminate coverage with respect to a Participant;

(iii) The date a Participant is no longer eligible for coverage under Article III, including without limitation as a result of the Participant's employer no longer being a Related Employer;

(iv) The date a Participant 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;

(v) The last date for which any required Participant contribution was made;

(vi) The date on which a leave of absence begins; and

(vii) The date a Participant terminates employment.

10.02 Severance. Eligibility for Plan coverage shall continue for an Employee to the extent provided under any severance arrangement between such Employee and the Company. The level of contribution and the conditions of such continuation coverage shall be determined by the terms of the applicable severance agreement.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.01 Assignment of Benefits. No benefit payable at any time under the Plan shall be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, bankruptcy, or, in any other manner, and no benefit payable under the Plan shall be liable for, or subject to, any obligation or liability of any Participant. If any Participant entitled to a benefit under the Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part thereof, or if by reason of his or her bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her spouse or dependents, in a manner the Plan Administrator deems proper.

11.02 Information to Be Furnished. Participants shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant any legal or equitable right against the Company, except as provided herein.

11.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

11.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

11.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, the Company shall not be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

11.07 Misrepresentation. Any material misrepresentation on the part of any Participant in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void.

11.08 Inadvertent Error. Inadvertent error by the Plan Administrator in the keeping of records or the transmission of any Enrollment Form shall not deprive any Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

11.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the Company's rights to discipline or terminate an Employee.

11.10 Participant Responsibilities. Each Participant is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate a Participant. If a Participant becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect, (2) the Participant 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.

11.11 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine:

any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization.

11.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 11.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this 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. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

11.13 Severability. In the event any portion of the Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of the Plan, and the balance of the Plan shall remain in full force and effect.

11.14 Participant Litigation. In any action or proceeding involving the Plan, Participants or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Participant or other person concerned. To the extent permitted by applicable law, an election to become a Participant under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

11.15 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

11.16 Notice. Any notice given under the Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Claims Administrator, when addressed to it at its office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Claims Administrator.

11.17 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XII
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

12.01 Plan Self Insured. The Plan is a self-insured plan. All contributions made to the Plan are used to pay claims and related expenses thereunder.

12.02 Participants' and Dependents' Rights Unsecured. The right of a Participant or any other person to receive a distribution hereunder, shall be an unsecured claim against the general assets of the Company and no Participant or any other person shall have any rights in any amount allocated for his or her benefit under the terms of the Plan, or any other specific assets of the Company. All amounts allocated pursuant to the terms of the Plan shall constitute general assets of the Company and may be disposed of by the Company at such time and for such purpose as it may deem appropriate. Benefits payable pursuant to the terms of the Plan shall be paid solely as required out of the general assets of the Company or from any other funding vehicle as may be established by the Company.

12.03 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Any amendment or restatement of the Plan shall not affect existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration. To the extent that any applicable collective bargaining agreement imposes a more restrictive requirement regarding Plan eligibility or benefits than is set forth herein, such requirement, as applied solely to those Employees subject to the collective bargaining agreement, is incorporated herein by this reference.

12.04 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

12.05 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article XII, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 22nd day of June, 2015, to be effective as of January 1, 2015.

NISOURCE BENEFITS COMMITTEE

By: ______________________________

One of the Members of the Committee

COLUMBIA GAS OF KENTUCKY, INC.
RESPONSE TO ATTORNEY GENERAL'S INITIAL
REQUEST FOR INFORMATION
DATED JULY 8, 2016

45. Reference the Columbia application generally. Has the Company raised premiums for employees or raised co-pays for doctor visits and/or pharmacy prescriptions in order to assist in keeping the insurance costs as low as possible?

Response:

Please see AG 1-44 Attachments C and G for premium, benefit copays, and pharmacy prescription copays for employees that were implemented to keep insurance costs as low as possible.