GOOD HEALTH IS IMPORTANT **TO YOUR SUCCESS**

YOUR
LIVE WELL
TOOLKIT

Live Well, Save Well!

my Pay | my Retirement | my Health | my Work/Life

The information included in this toolkit has been prepared to summarize some provisions of the plans and is not intended to be a complete summary of the plans. To the greatest extent possible, non-technical language has been used to explain some of the plans' provisions. The official plan texts are the governing documents if questions arise. While NiSource intends to continue the plans described in this toolkit, the company reserves the right to change or discontinue any or all of them at its discretion and without prior notice to any person, subject to the provisions of collective bargaining agreements.

AT NISOURCE, WE BELIEVE THAT YOUR GOOD HEALTH IS IMPORTANT TO YOUR SUCCESS — AND OURS.

That's why we provide you with a variety of resources to help you better manage your health and improve your wellness throughout the year, including:

- Company-subsidized medical, dental and vision coverage (you pay a portion of the premiums, but NiSource pays the majority of the cost)
- Free (no copayment required) in-network preventive services and immunizations
- Smoking-cessation products that are eligible prescription drugs under the HD PPO 1, HD PPO 2 and PPO plans
- No-cost coverage under the Employee Assistance Program (EAP)
- The MySource for HR website (mysourceforhr.com) and Benefits Source, where you can go for information and answers about enrolling in and using your NiSource health coverage

Making the best use of these and other available resources (like health information publicly available on the Internet) can be challenging—and confusing! But don't worry—your **LIVE WELL TOOLKIT** will help you make sense of it all.

Inside you'll find a wealth of information about how to best use your NiSource-provided health and wellness benefits and resources, including:

- An overview of your medical plan coverage
- Information on how to assess your current health status
- Preventive care guidelines
- Tips for getting the most from your health plan
- Resources to help you manage health conditions and improve your health
- Suggestions for when you need to receive care
- And more!

Be sure to familiarize yourself with the contents of this toolkit, and keep it in a safe place for future reference. NiSource is pleased to provide you with this **LIVE WELL TOOLKIT**, and we hope it helps lead you to better health in the year ahead.

HOW HEATHLY ARE YOU?

For many people, that question is difficult to answer. There's no single test or method for determining a person's overall health.

There also are a great many factors that influence your health. You have control over some of these factors, like your diet, alcohol and tobacco use and level of physical activity. Other factors are out of your control, such as your genetic makeup and family medical history.

Although assessing your current health status can be complicated, it's important to know where you stand before you can create a plan for maintaining or improving your health in the future.

Here are some steps you can take to better understand your current health status.

KNOW YOUR NUMBERS

One way to measure your current health is through biometric screening, which involves a group of tests that measures various aspects of your body. The results of biometric screening can be used to identify prior, current or possibly even future medical issues. Typically, biometric screening includes these components:

Body Mass Index (BMI)

Your BMI is calculated based on your height and weight. BMI provides an indicator of body fatness and is used to screen for weight-related issues that may lead to health problems. A healthy BMI range is from 18 to 25. Anyone with a BMI over 30 is considered obese.

Cholesterol Levels

When you have a biometric screening, your health care provider will determine your lipid profile by taking a small amount of blood from your finger. High cholesterol can lead to a wide variety of health problems, including heart disease. Typically, a biometric screening will assess your:

LDL CHOLESTEROL is often called "bad cholesterol" because it can build up on the walls of your arteries and increase your chances of having heart disease. The lower your LDL cholesterol number, the lower your risk.

LDC CHOLESTEROL LEVEL	CATEGORY
Less than 100	Optimal
100-129	Near Optimal
130-159	Borderline High
160-189	High
190 and Above	Very High

HDL CHOLESTEROL is often referred to as "good cholesterol" because it actually protects against heart disease by taking the LDL "bad" cholesterol out of your blood and keeping it from building up in your arteries. When it comes to HDL cholesterol, a higher number means lower risk.

HDC CHOLESTEROL LEVEL	CATEGORY
60 and Above	Optimal (Lower Risk)
Less than 50 in Women Less than 40 in Men	Low (Higher Risk)

TRIGLYCERIDES primarily come from the food we eat (animal fat and vegetable oil). Excess calories, alcohol or sugar in the body can be converted to triglycerides and stored in fat cells throughout the body. A high triglyceride level has been linked to the risk of coronary artery disease.

TRIGLYCERIDE LEVEL	CATEGORY
Less than 150	Normal
150-199	Mildly High
200-499	High
500 and Above	Very High

TOTAL BLOOD CHOLESTEROL is a measure of LDL cholesterol, HDL cholesterol and other lipid components. Doctors recommend total cholesterol levels below 200.

TOTAL BLOOD CHOLESTEROL LEVEL	CATEGORY
Less than 200	Desirable
200-239	Mildly High
240 and Above	High

BLOOD GLUCOSE LEVELS

A biometric screening may include a blood glucose test to measure the amount of glucose (a type of sugar) in your blood. Glucose is the main source of energy used by the body. Insulin is a hormone that helps your body's cells use glucose. Insulin is produced in the pancreas and released into the blood when the amount of glucose in the blood rises.

High blood glucose levels may cause health problems associated with diabetes, including eye, kidney and liver damage. Low blood glucose levels may be a sign of hypoglycemia and can include symptoms such as lethargy, impaired mental functioning, passing out and irritability.

The appropriate blood glucose level can vary from person to person based on a variety of factors. You should consult your doctor for your ideal blood glucose level.

BLOOD PRESSURE

Another part of biometric screening is measuring your blood pressure. High blood pressure (called hypertension) is linked to the increased risk of stroke and heart disease. It's important to know if your blood pressure is too high (or too low) so you can take appropriate actions (diet, exercise, medication, etc.) to get it to the right level.

Blood pressure is typically recorded as two numbers:

- Systolic measures the pressure in the arteries when the heart beats
- Diastolic measures the pressure in the arteries between heart beats

A blood pressure reading will have the systolic measure on top of the diastolic measure (for example, 110 over 80).

The chart below reflects blood pressure categories defined by the American Heart Association:

SYSTOLIC LEVEL (mm Hg)	DIASTOLIC LEVEL (mm Hg)	CATEGORY
Less than 120	Less than 80	Normal
120-129	Less than 80	Elevated
130-139	80-89	Hypertension (Stage 1)
140 and Higher	90 or Higher	Hypertension (Stage 2)
Above 180	Above 120	**Hypertension Crisis (Immediate Care Needed)**

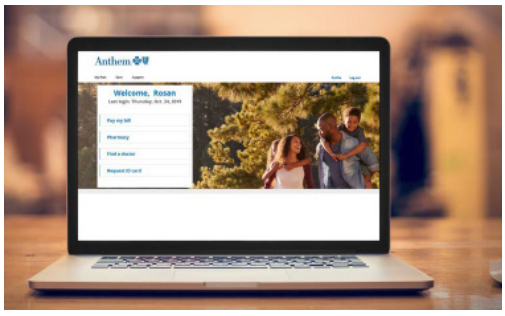
HOW OFTEN

Many health care experts say biometric screening should be done annually as part of a person's regular health maintenance routine. The HD PPO 1, HD PPO 2 and PPO medical plans all cover biometric screening under preventive care (see Preventive Care Overview for more details).

Once you obtain your biometric screening results and understand what they mean, you are on the road to making healthier decisions.

COMPLETE A HEALTH ASSESSMENT

Completing an online health assessment is another step you can take toward achieving wellness. Available through the Anthem website, the interactive **MyHealth Assessment** will help you evaluate your health status. You'll spend a few minutes answering questions about your current health, lifestyle and health history. Then, based on your answers, the assessment tool will generate your health score and personal health risk profile, plus a personalized action plan with realistic solutions tailored toward helping you reach your health goals.



Your assessment results and action plan will tell you:

- How you're stacking up healthwise
- Where you can make improvements, with some suggestions to get you started
- If you qualify for other health programs that may be offered through your medical plan at no additional cost to you

To get started, log in to the Anthem website at **anthem.com**. From the home page, navigate to **MyHealth Dashboard**, select Programs, and then click on "WebMD Health Risk Assessment." Before you begin the assessment, be sure to have available:

- Your medical ID card
- Your height and weight
- Your blood pressure, blood glucose, cholesterol and triglyceride values (these are available from your biometric screening results)
- The month and year of your last physical (or any relevant health screenings)

If you aren't sure of any of this information, you can answer "I don't know" on the health assessment.

MyHealth Assessment is free, completely confidential, and takes only about 15 minutes to complete. When you are finished, you will be able to print your personalized profile and action plan for your reference or to share with your doctor.

Preventing illness is an important step in maintaining good health. NiSource wants to be sure that you (and your covered family members) get the preventive care you need to avoid serious illness. That's why the HD PPO 1, HD PPO 2 and PPO medical plans provide coverage at no cost (no copayment required) for "routine" preventive care services.

WHAT IS ROUTINE PREVENTATIVE CARE?

Services like annual health exams, blood pressure and cholesterol tests and immunizations are all examples of routine preventive care. Health care experts generally agree that, when received on a regular basis, these services play an essential role in helping the average person maintain good health and prevent serious health issues.

If, based on your health history or other factors, you and your doctor determine that you should have certain procedures more often or at an earlier age than outlined in the guidelines, those services are not considered "routine."

COVERED SERVICES

These preventive care services are 100 percent covered by your medical plan:

- Biometric screening
- Routine physical exams and checkups (including a routine hearing exam and annual diabetes eye exam)
- Immunizations (including hepatitis B vaccine)
- Routine Pap smears
- Routine prostate-specific antigen tests (PSAs)
- Routine colorectal cancer (colonoscopy) screenings*
- Routine mammograms*
- Diabetic education/training
- Well-baby doctor office visits
- All additional routine labs and X-rays associated with routine office visits

Services provided for members who have current symptoms or have been diagnosed with a medical condition will not be considered preventive and will not be paid at 100 percent. These services will be processed with a medical diagnosis (not a preventive diagnosis) and paid according to plan provisions. Please contact Anthem at **1-800-228-2891**.

* Effective Jan. 1, 2012, NiSource will cover one in-network colonoscopy and one in-network mammogram due to a non-preventive diagnosis at 100 percent. Each covered member is limited to one colonoscopy and one mammogram per year regardless of preventive diagnosis.

HEALTH SCREENING GUIDELINES

CHILDREN 0-18 YEARS

AGE	SCREENING TEST	FREQUENCY
Newborn	Newborn Exam in Hospital	During Newborn Period
Newborn	Newborn Screening (PKU, Sickle Cell, Hemoglobinopathies, Hypothyroidism)	During Newborn Period
1, 2, 4, 6, 9, 12 and 18 Months	Physical Exams	At Month Listed
Birth - 2 Months	Head Circumference	At Each Well-Child Visit
Birth - 2 Years	Length and Weight	At Each Well-Child Visit
18 Months - 18 Years	Physical Exams	Annually
2 - 18 Years	Height and Weight	At Each Well-Child Visit
3 - 4 Years	Eye Screening	Once
Younger than 5 Years	Dental Exam	At Each Well-Child Visit

ADULTS OVER AGE 18

SCREENING	AGE										
	18	25	30	35	40	45	50	55	60	65	70
Physical Exam (Including Blood Pressure and Weight)	Annually										
Cholesterol				Men: Every 5 Years							
						Women: Every 5 Years					
Cervical Cancer Screening/ Pap Smear	Women: Annually										
Mammography					Women: Every 2 Years						
Colorectal Cancer											
Sigmoidoscopy							Every 5 Years				
Double-Contrast Barium Enema							Every 5 Years				
Fecal Occult Blood Test							Men: Annually				
Colonoscopy							Every 10 Years				
PSA Test (Men)							Men: Annually				
Thyroid (TSH)							Every 5 Years				
Osteoporosis							At Age 50				
Alcohol Use, Depression	Periodically										

Note: Guidelines may differ based on family history. See **ahrq.gov** for more information.

IMMUNIZATION SCHEDULES

CHILDREN 0-6 YEARS

VACCINE	AGE: MONTHS									AGE: YEARS						
	BIRTH	1	2	4	6	12	15	18	19-23	2-3	4-6	7-10	11-12	13-14	15	16-18
Hepatitis B	Hep B	Hep B			Hep B							Hep B Series				
Rotavirus			RV	RV	RV											
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				DTaP		Tdap	Tdap		
Haemophilus Influenzae Type B			Hib	Hib	Hib	Hib										
Pneumococcal			PCV	PCV	PCV	PCV						PCV Series (High Risk Children Only)				
Inactivated Poliovirus			IPV	IPV	IPV						IPV	IPV Series				
Influenza					Annually											
Measles, Mumps, Rubella						MMR					MMR	MMR Series				
Varicella (Chicken Pox)						Varicella					Vari-cella	Varicella Series				
Hepatitis A						Hep A (2 Doses)						Hep A Series (High Risk Children Only)				
Human Papillomavirus (Females)													HPV	HPV		
Meningococcal													MCV4 Dose 1	MCV4 Dose 2		

Yellow areas indicate the vaccine should be given if a child is catching up on missed vaccines.

ADULTS OVER AGE 18

VACCINE	AGE										
	18	25	30	35	40	45	50	55	60	65	70
Tetanus-Diptheria	Every 10 Years										
Varicella	2 Doses										
Measles, Mumps, Rubella	If Not Already Immune										
Pneumococcal										1 Dose	
Influenza	Annually										
Hepatitis B/Hepatitis A	High-Risk Adults Only										
Meningococcal	High-Risk Adults Only										
Human Papillomavirus (Female)	3 Doses										

Immunization Schedule Source: Department of Health and Human Services, Centers for Disease Control and Prevention.

Please note that guidelines for health screenings and immunizations may differ for anyone in a high-risk category. Talk to your doctor if you have questions.

WHO PAYS FOR WHAT?

Here's a refresher on how your medical plan works during the year.

Take Advantage of an HSA

If you enrolled in HD PPO 1 or HD PPO 2, you have access to a Health Savings Account (HSA), which you can use to set aside before-tax dollars to pay for qualified medical expenses (including your annual deductible or other out-of-pocket medical costs).

During the annual enrollment period in the fall, you indicate how much you want to contribute to your HSA. When you enroll in an HD PPO option and open an HSA, NiSource will contribute money to your account each year—$1,200 if you enroll in HD PPO 1 or $700 if you enroll in HD PPO 2.

Any dollars in your HSA that you don't use can be saved and used for future medical expenses. There is no "use it or lose it" rule when it comes to your HSA.

Annual Deductible

This is the amount you pay each year before plan benefits begin. Your annual deductible amount varies based on the medical plan and level of coverage you elected for the year. See Your Medical Plan Overview for the annual deductible amount that applies to you.

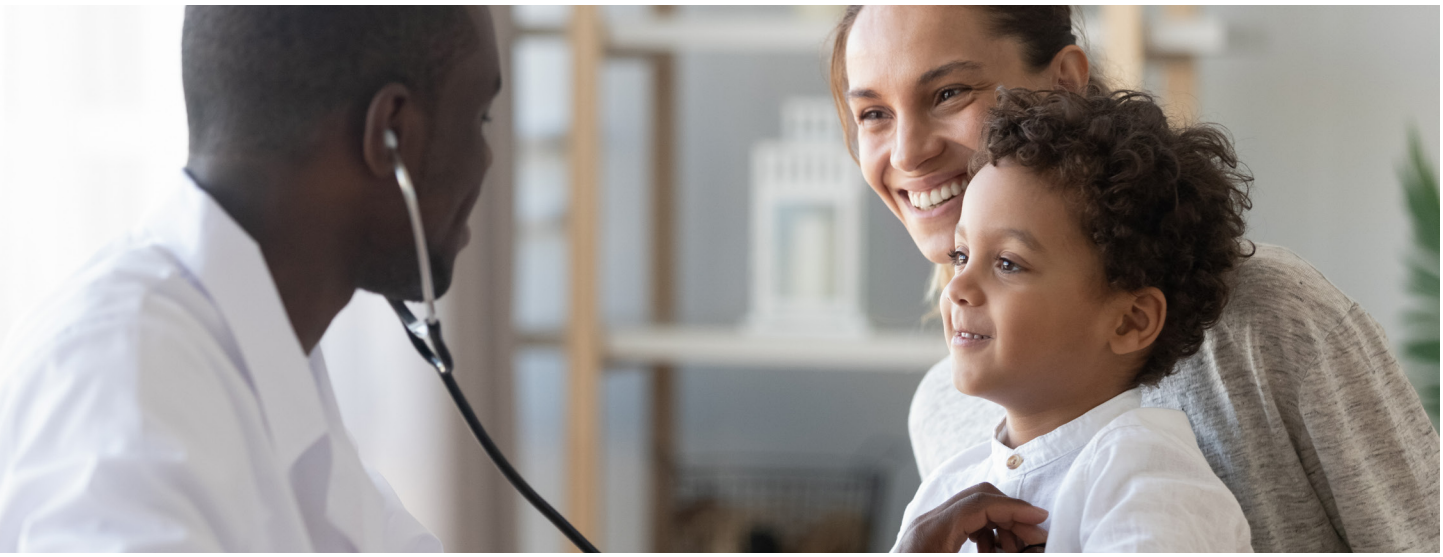
Any time you receive care and an insurance claim is submitted (either by your doctor or you) that requires you to pay a portion of the cost, Anthem will send you an Explanation of Benefits (EOB) that shows the total amount you've paid toward your annual deductible. You also can track the progress toward meeting your annual deductible on the Anthem website (**anthem.com**) or by calling Anthem member services at **1-800-228-2891**.

Remember, if you have an HSA, you can use funds from that account to meet all or a portion of your annual deductible. If your HSA funds are used up before your annual deductible is met, you will need to pay any expenses out of your pocket until the deductible is met.

REMEMBER TO USE IN-NETWORK PROVIDERS

One way to make your health care dollars stretch farther is by using in-network providers whenever you need care. With in-network providers, you save two ways:

- First, the plan will pay a larger portion of the cost if you use an in-network provider than it will if you use a provider from outside the network.
- Second, the plan has negotiated special pricing with all in-network providers, which means the total cost of your care will be less than if you use an out-of-network provider.



Co-Insurance or Copayment

Once you meet your deductible, the plan will begin paying a portion (or all in the case of preventive care) of your plan costs until you reach the out-of-pocket maximum. You pay your share of the cost through either co-insurance or a copayment:

- Co-insurance is the percentage of the total cost of the service or treatment that you pay.
- A copayment is a specific dollar amount you pay for a service or treatment (and the plan pays the remaining cost).

For example, if you are in HD PPO 1 or HD PPO 2 (and your annual deductible is met), and you visit an in-network doctor or specialist for treatment, the plan will pay 80 percent of the cost of that visit and you will pay the remaining 20 percent.

If you are in the PPO (and your annual deductible is met), and you visit an in-network doctor or specialist for treatment, you will pay a copayment for that visit and the plan will pay the remaining portion of the bill.

Refer to Your Medical Plan Overview for more details.

Out-of-Pocket Maximum

This is the safety net that protects you from the burden of unexpectedly large health care expenses by limiting the amount you pay out of your pocket for eligible medical services each year. Once you have met the out-of-pocket maximum for the year, the plan will pay 100 percent of any eligible expenses for the rest of
the year.

Your out-of-pocket maximum varies based on the medical plan and level of coverage you elected for the year. See Your Medical Plan Overview for the out-of-pocket maximum that applies to you.

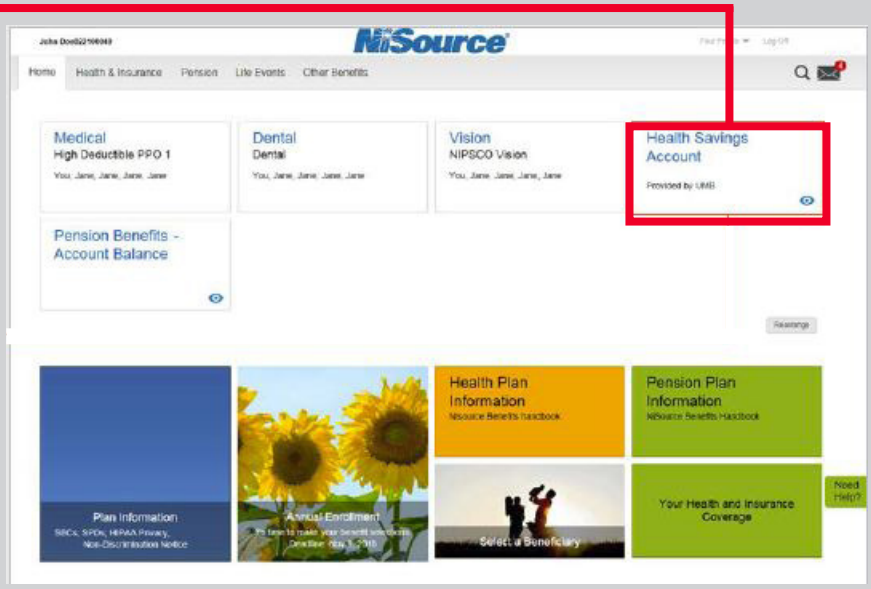
TRACKING YOUR HSA BALANCE

If you have an HSA, you should keep track of how much money you have in your account throughout the year. If you pay for your portion of services with money from your account, you will want to know if your balance is low or depleted because you may need to pay out of your own pocket instead.

If your balance is low or depleted, you have the option of paying out-of-pocket and then reimbursing yourself once funds in your HSA are available.

To track your HSA balance, go to the MySource for HR website at **mysourceforhr.com** and choose the Health Savings Account tile located on the homepage. There, you can fully manage your HSA, including signing up for text alerts to notify you when your balance is low.

The Your Spending Account website has information about your HSA, including your account balance and direct deposit information. You may also choose alternative ways of depositing money into your account (fees may apply).



PARTICIPANT ADVOCACY: THERE WHEN YOU NEED IT

Participant Advocacy is available to you at no cost. This service can help you resolve issues related to your coverage or your dependent's coverage. Advocates work on your behalf to:

- Resolve issues with your health plan related to claims or billing dIsputes;
- Access the health care you need, including obtaining authorization and referrals and resolving network issues; and
- Provide health care information and education, including plan comparisons and treatment options.

All calls are confidential and completely free. To speak with an advocate, call **1-888-640-3320** and say "representative" after the initial greeting; then ask to be referred to an advocate. (For claims issues, please make one attempt to resolve it on your own before calling the Participant Advocacy Service.)

UNDERSTANDING YOUR ANTHEM CLAIM RECAP

Each time you or a health care provider files a claim with your health plan, Anthem Blue Cross and Blue Shield (Anthem) gives you a claim recap. The recap helps you see how your High Deductible Preferred Provider Organization (HD PPO) plan works for you. It describes the services received, what they cost and how your plan handled the claim.

To view your claim recap, log in to anthem.com and go to the "Claims" section. We'll also send a copy in the mail if you owe any money toward the claim. If you don't want to get a copy in the mail, see below for a quick how-to on going paperless.

Here are the key things to look for on your Health Care Summary, also called Explanation of Benefits (EOB)

1. Claims Summary:

- Amount of the claim
- Amount of any discounts
- Amount Anthem paid
- Amount you'll need to pay out of pocket, if any

Anthem Blue Cross and Blue Shield
3075 Vandercar Way
Cincinnati, OH 45209

Anthem

Don't worry, this is not a bill.

Jane Q. Member
123 Main Street, Apt #2
Indianapolis, IN 46268

Hi Jane – Here's your
Health Care Summary
November 12, 2020.

Also called an Explanation of Benefits (EOB), it shows you the care you received and who paid for it. Your EOB also includes information about saving money on health care and tips for staying healthy.

Need help in a different language? Call us.
¿Necesita ayuda en español? Llámenos.
1-800-123-456

Helpful resources

Use **Sydney Health**, the *Anthem Blue Cross member mobile app*, or **anthem.com** to check on claims, review your benefits and find care.
Text Syd help to 268496 to download the Sydney Health app.

Call
1-800-123-4567 TTY/TDD: 711

Look for 2 savings opportunities inside!

1

Claims summary

Doctor/facility charges:	$983.00
Your discounts:	– 584.03
Due to your doctor/facility (max allowed):	$398.97
Anthem Blue Cross paid:	– 0.00
What you pay:	$398.97

Preventive care reminders*

For Jane
☐ Breast cancer screening ☐ Colon cancer screening
☐ Diabetes check

For Tom
☐ Child well-care visit ☐ Flu shot

For Ben
☐ Child well-care visit ☐ Flu shot

*Your checklist is based on age and gender guidelines from the Centers for Disease Control and Prevention. If you have been to the doctor recently, it may not reflect your most recent services.

Tips and tools

Want us to email you instead?
Sign up to receive EOBs by email instead of mail. Use our **Sydney Health** mobile app or log in to **anthem.com** to change your profile.

Urgent care without the urgent cost
If it's not an emergency, try an urgent care instead of the ER. It could save you an average of $500. **UrgentCare Indy** is close by at 7911 N Michigan Rd, Indianapolis, IN 46268, 1-317-960-3278.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCICI). Compcare underwrites or administers HMO or POS policies, WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
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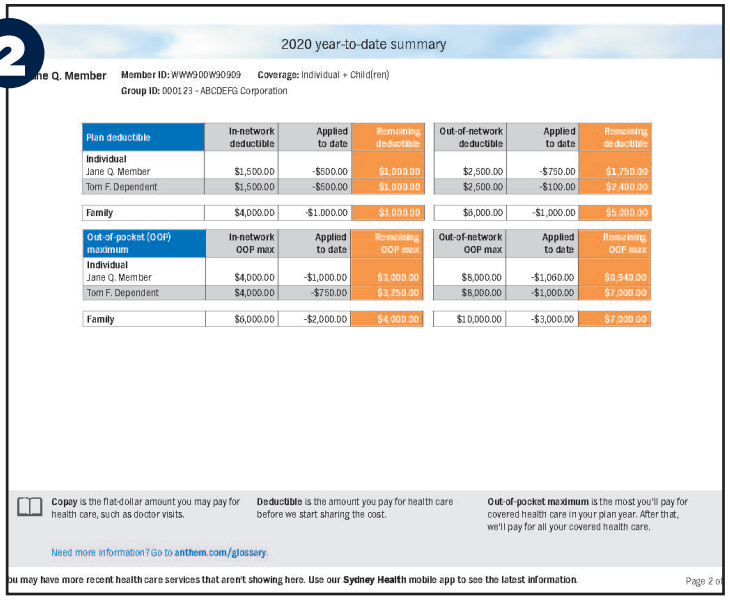
2. Year to Date Summary:

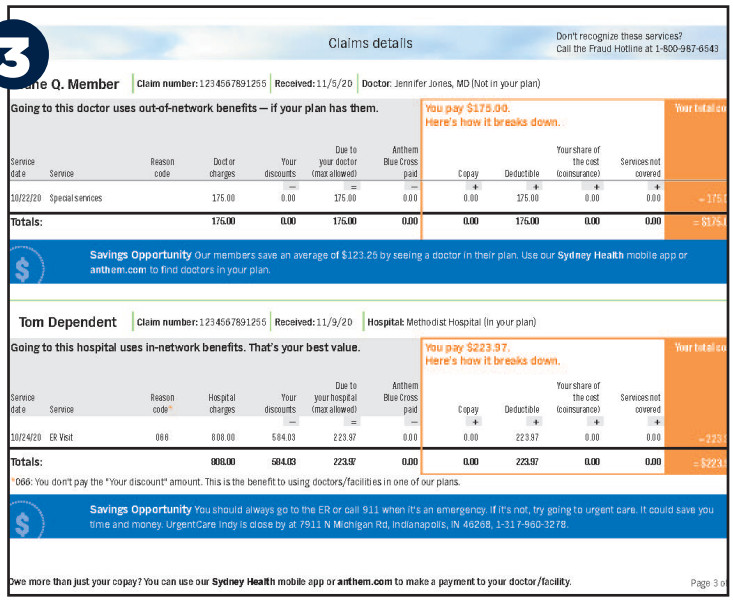
Amount you've spent on covered services during the plan year—a good way to see how much is left before your traditional health coverage kicks in or you reach your annual out-of-pocket maximum

- Amount that applies toward reaching the traditional health coverage portion of the plan—when you and the plan each pay a percent of the cost for covered services



3. Claim payment details:

A breakdown of the claim, including the amounts paid through traditional health coverage



HOW TO GET YOUR HEALTH PLAN CLAIM RECAPS ONLINE*

1. Log into anthem.com (if you haven't registered yet, you'll need to register to log in)
2. Select "Update profile access and settings" from the homepage
3. Select "Plan Notifications" from the Communication Preferences section
4. Choose "Email" for Explanation of Benefits (EOBs)
5. Select "Save/Update"

* Only the primary person on the plan (the subscriber) can pick this option.

RESOURCES TO MANAGE AND IMPROVE YOUR HEALTH

Anthem Health Management Services

By participating in the HD PPO 1, HD PPO 2 or PPO medical plans, you have access to the following services through Anthem.

Future Moms

Use Anthem's toll-free number **(1-800-228-2891)** to get answers to your questions about important health topics such as pregnancy, labor, nursing and postpartum depression. The line is staffed by registered nurses 24 hours a day, seven daysa week. There is no cost to you for the program. When you call, Anthem will send you a helpful prenatal care book, educational materials and other tools to help you manage your pregnancy.

Integrated Health Model (IHM)

If you enroll in an Anthem health plan, you will have access to an Anthem personal health consultant who is a trained health professional dedicated to your needs—at no cost to you. You can get the support you need to meet health goals such as losing weight or quitting smoking, as well as handle a serious health problem or arrange care if you need a surgery or procedure. To get started, call the Member Services number on your ID card.

24-Hour NurseLine

You can get helpful answers to thousands of health questions ... all from registered nurses. Call the NurseLine toll-free anytime day or night. Please refer to the NurseLinephone number located on the back of your medical ID card.

Telemedicine

You can connect with a doctor without leaving your home or office simply by using your smartphone, tablet or computer Available to all Anthem health plan members, LiveHealth Online provides 24/7 access to board-certified doctors who can assess your condition, provide treatment options and, if needed, send a prescription to the pharmacy of your choice. It is a convenient and cost-effective option for receiving medical care in non-urgent situations. Visit **anthem.com** to learn more or sign up at **livehealthonline.com** or download the free LiveHealth app to your mobile device.

GOING TO THE DOCTOR

No one loves going to the doctor, but the experience doesn't need to be one you dread. Follow these suggestions to help make your next doctor visit more successful.

Get Prepared and Stay Involved
Research shows that people who ask good questions and invest time to learn about their conditions get better health results. To make the most of the time you have with your doctor, spend some time preparing before your appointment.

- Create a list of any symptoms you are having and note how long you've had them.
- Identify any medications you are currently taking (list all prescriptions, over-the-counter medicine and supplements).
- Know and be prepared to share your medical history (personal and relevant family history).

As you are meeting with the doctor, don't hesitate to ask questions—even if you think they are tough or uncomfortable. By asking questions, you show that you're engaged in your own health and interested in being a better health care consumer.

If your doctor recommends treatment or surgery, you should ask...

- What are the risks of this treatment or surgery? What are the benefits? What are the likely outcomes?
- What is the cost of this treatment or surgery?
- What are my alternatives? What are the benefits and risks associated with each alternative?
- How long will it take to recover? What complications, pain or side effects might I have?
- Which doctor, hospital or surgery center is qualified and experienced in this treatment or procedure?
- What may happen if I don't treat my condition at this time?
- If I choose to get a second opinion, whom should I see?

If your doctor recommends a prescription drug, you should ask...

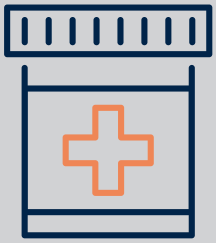
- If the medicine is a brand-name, is there a generic available?
- Is there an over-the-counter medication available that may be as effective which I could try first?
- What should I do if I forget to take the medicine and miss a dose?
- How will other drugs (including herbs and supplements) I am taking affect me while I'm taking the medicine?
- Are there any restrictions on activities while I'm taking the medicine?
- What are the possible side effects?

After Your Doctor Office Visit...

Once you and your doctor agree on a course of treatment, stay in volved in the process. You may not be a health care professional, but you do have a vested interest in a successful outcome! Here are some suggestions:

- Clarify what you've heard from your doctor. Repeat important information the doctor shared with you back to him or her to make sure you understand it. If necessary, make a follow-up appointment with your doctor.
- Get the results of any test or procedure. Review the results and ask about the implications on your care. If you do not receive the results when expected—in person, on the phone or in the mail—call your doctor and ask for them. Don't automatically assume everything is fine because you haven't heard anything.
- Learn about your medical issue by researching it on your own. There's a wide variety of reputable medical resources available to you at your local library or on the Internet. The more you know about your condition, the better decisions you can make.
- If you need hospital care, weigh your options. Because all hospitals can treat a wide range of problems, you should ask your doctor to help you identify and discuss your options. Research shows that for some procedures (such as heart bypass surgery), results are often better at hospitals that perform these procedures on a regular basis.

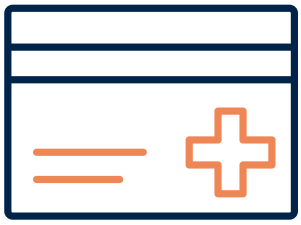
HD PPO PLANS: PRESCRIPTION DRUG COVERAGE



All prescription drug costs are subject to the deductible before 80 percent co-insurance. Be sure to show your Anthem ID card at the point of purchase to ensure that you receive the Anthem in-network discount and that your claim counts toward your deductible. If you reach your out-of-pocket maximum, the plan will pay 100 percent of eligible prescription drug costs for the rest of the calendar year.

Because you will need to pay out-of-pocket for prescription drugs until you meet the deductible, be sure to research drug costs to better understand your out-of-pocket expenses. issues, please make one attempt to resolve it on your own before calling the Participant Advocacy Service.)

Handling Payment



Any time you receive care from a provider, follow these steps to ensure that you pay only the amount you owe:

1. Present your Anthem medical plan ID card to the doctor or receptionist.
2. Ask what the charges are for the services provided.
3. Ask the doctor to file a claim with Anthem.
4. After the claim is processed, you will receive a statement from Anthem telling you how much you owe.

If you haven't met the plan's annual deductible yet, you may be responsible for paying some or all of the cost of your care (depending on the plan in which you are enrolled). It's still important for the claim to be submitted because Anthem will track your progress toward satisfying the deductible. Remember, some services (like preventive care) are 100 percent covered and not subject to the annual deductible.

If you have met the annual deductible, you will pay only a portion of the cost for service (co-insurance or copayment). The amount you owe will be reflected on your Anthem statement.

If you have met the annual out-of-pocket maximum, the plan will pay 100 percent of the cost for in-network service.

MEDICAL PLAN FACTS

Coverage provided by Anthem
Website: **anthem.com**
Phone: **1-800-228-2891**

	In-Network	Out-of-Network
Annual deductible	$1,500 employee only $3,000 employee + spouse; employee + child(ren); and family	$3,000 employee only $6,000 employee + spouse; employee + child(ren); and family
Primary doctor office visit	80% covered after deductible is met	60% covered after deductible is met
Specialist office visit	80% covered after deductible is met	60% covered after deductible is met
Emergency room visit (not followed by admission)	80% covered after deductible is met	80% covered after deductible is met
Annual out-of-pocket maximum (includes deductible)	$3,000 employee only $6,000 employee + spouse; employee + child(ren); and family	$6,000 employee only $12,000 employee + spouse; employee + child(ren); and family
Lifetime coverage limit	Limit does not apply	Limit does not apply
Hospital copay	Not applicable	Not applicable
Preventive care (see "Preventive Care Overview" for details on what your plan covers)	100% covered	100% covered
Allergy tests and treatment	80% covered after deductible is met	60% covered after deductible is met
Inpatient hospital care (semi-private room)	80% covered after deductible is met	60% covered after deductible is met
Inpatient hospital care (private room)	80% covered after deductible is met	60% covered after deductible is met; must be medically necessary
Mental health and substance abuse care	80% covered after deductible is met	60% covered after deductible is met

Prescription Drug Facts

Coverage provided by Anthem Prescription Services (APS)
Website: **anthem.com**
Phone: **1-800-228-2891**

	In-Network	Out-of-Network
Benefits covered under medical deductible?	Yes	Yes
Benefits covered under medical out-ofpocket maximum?	Yes	Yes
Retail (generic, formulary brand and non-formulary brand)	80% covered after deductible is met; 30-day supply	60% covered after deductible is met; 30-day supply
Mail order (generic, formulary brand and non-formulary brand)	80% covered after deductible is met; 90-day supply	N/A

MEDICAL PLAN FACTS

Coverage provided by Anthem
Website: **anthem.com**
Phone: **1-800-228-2891**

	In-Network	Out-of-Network
Annual deductible	$2,500 employee only $5,000 employee + spouse; employee + child(ren); and family	$5,000 employee only $10,000 employee + spouse; employee + child(ren); and family
Primary doctor office visit	80% covered after deductible is met	60% covered after deductible is met
Specialist office visit	80% covered after deductible is met	60% covered after deductible is met
Emergency room visit (not followed by admission)	80% covered after deductible is met	80% covered after deductible is met
Annual out-of-pocket maximum (includes deductible)	$5,000 employee only $9,100 per person, not to exceed $10,000 combined family	$10,000 employee only $20,000 employee + spouse; employee + child(ren); and family
Lifetime coverage limit	Limit does not apply	Limit does not apply
Hospital copay	Not applicable	Not applicable
Preventive care (see "Preventive Care Overview" for details on what your plan covers)	100% covered	100% covered
Allergy tests and treatment	80% covered after deductible is met	60% covered after deductible is met
Inpatient hospital care (semi-private room)	80% covered after deductible is met	60% covered after deductible is met
Inpatient hospital care (private room)	80% covered after deductible is met	60% covered after deductible is met; must be medically necessary
Mental health and substance abuse care	80% covered after deductible is met	60% covered after deductible is met

Prescription Drug Facts

Coverage provided by Anthem Prescription Services (APS)
Website: **anthem.com**
Phone: **1-800-228-2891**

	In-Network	Out-of-Network
Benefits covered under medical deductible?	Yes	Yes
Benefits covered under medical out-ofpocket maximum?	Yes	Yes
Retail (generic, formulary brand and non-formulary brand)	80% covered after deductible is met; 30-day supply	60% covered after deductible is met; 30-day supply
Mail order (generic, formulary brand and non-formulary brand)	80% covered after deductible is met; 90-day supply	N/A

MEDICAL PLAN FACTS

Coverage provided by Anthem
Website: **anthem.com**
Phone: **1-800-228-2891**

UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS

	In-Network	Out-of-Network
Annual deductible	$300 employee only $600 employee + spouse; employee + child(ren); $900 family	$600 employee only $1,200 employee + spouse; employee + child(ren); $1,800 family
Primary doctor office visit	$20 copay	60% covered after deductible is met
Specialist office visit	$20 copay	60% covered after deductible is met
Emergency room visit (not followed by admission)	100% covered for accidents (true emergencies); 80% covered after deductible is met for medical and non-medical services	
Annual out-of-pocket maximum (includes deductible and copays)	$1,300 employee only $2,600 employee + spouse; employee + child(ren); $3,900 family	$2,600 employee only $5,200 employee + spouse; employee + child(ren); $7,800 family
Lifetime coverage limit	Limit does not apply	Limit does not apply
Hospital copay	Not applicable	Not applicable
Preventive care (see "Preventive Care Overview" for details on what your plan covers)	100% covered	60% covered after deductible is met
Allergy tests and treatment	Testing covered at 100% after $20 copay; serums and injections covered at 100% with no deductible or copay	60% covered after deductible is met for injections, serums and office visit testing
Inpatient hospital care (semi-private room)	80% covered	60% covered after deductible is met
Inpatient hospital care (private room)	80% covered at semi-private rate; you are responsible for paying the difference between private and semi-private rooms	60% covered after deductible is met
Mental health and substance abuse care	$15 copay	65% covered after deductible is met
Mental health and substance abuse care (inpatient care)	85% covered after deductible is met	65% covered after deductible is met

Prescription Drug Facts

Coverage provided by Anthem Prescription Services (APS)
Website: **anthem.com**
Phone: **1-800-228-2891**

	In-Network	Out-of-Network
Benefits covered under medical deductible?	No	No
Annual out-of-pocket maximum	$1,500 per individual/$9,300 family	Check with plan
Retail generic	80% covered, $5 minimum copay, $15 maximum copay, 30-day supply	
Retail formulary brand	80% covered, $15 minimum copay, $45 maximum copay, 30-day supply; if you request a branded drug when a generic is available, you pay the difference in cost	
Retail non-formulary brand	80% covered, $30 minimum copay, $90 maximum copay, 30-day supply; if you request a branded drug when a generic is available, you pay the difference in cost	
Mail order generic	$10 copay, 90-day supply	
Mail order formulary brand	$30 copay, 90-day supply; if you request a branded drug when a generic is available, you pay the difference in cost	
Mail order non-formulary brand	$60 copay, 90-day supply; if you request a branded drug when a generic is available, you pay the difference in cost	

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IMPORTANT BENEFITS INFORMATION ENCLOSED

Private and Confidential