NiSource®

Health and Welfare Benefits Handbook

SUMMARY PLAN DESCRIPTIONS

Effective January 1, 2021

For Retirees who were

(i) Former Full-Time Employees of Northern Indiana Public Service Company LLC Represented by the USW Bargaining Union

and who were

Hired or Rehired before June 1, 2004, and Retired on or after February 1, 2017,

Hired or Rehired on or after June 1, 2004 and before June 1, 2009, and Retired on or after February 1, 2017, or

Hired or Rehired on or after June 1, 2009, and Retired on or after June 1, 2019; or

(ii) Former Full-Time Employees of Kokomo Gas and Fuel Company or of Northern Indiana Fuel and Light Company, Inc. Represented by the USW Bargaining Union

and who were

Hired before January 1, 2012 and Retired on or after January 1, 2015

RBPs 221Y17, 225Y17, 226Y19, 321Y15, and 721Y15

Contents

Benefits Program Overview

The Benefit of Choice – An Introduction to the Program

The benefit information contained in this Handbook applies to eligible retired employees

(A) who were

(i) former full-time employees of Northern Indiana Public Service Company LLC ("NIPSCO") represented by the USW Local 12775 or Local 13796 (each a "NIPSCO USW Union") that were (1) hired or rehired before June 1, 2004 and who retired on or after February 1, 2017, (2) hired or rehired on or after June 1, 2004 and before June 1, 2009 and who retired on or after February 1, 2017, or (3) hired or rehired on or after June 1, 2009 and who retired on or after June 1, 2019, or

(ii) former full-time employees of (a) Kokomo Gas and Fuel Company ("Kokomo"), and subsequently of NIPSCO after the merger of Kokomo into NIPSCO, represented immediately prior to retirement by a NIPSCO USW Union; or (b) Northern Indiana Fuel and Light Company, Inc. ("NIFL"), and subsequently of NIPSCO after the merger of NIFL into NIPSCO, represented immediately prior to retirement by a NIPSCO USW Union, and all of whom were hired before January 1, 2012 and retired on or after January 1, 2015; and

(B) who are covered under one or more of the NiSource Life and Medical Benefits Program, the NiSource Welfare Benefits Program, and the NiSource Post-65 Retiree Medical Plan (collectively, the "Program"), or various component benefit plans of the foregoing.

For Program recordkeeping purposes, the Plan Administrator, in its discretion, has designated such eligible retirees as belonging to Retiree Benefit Programs 221Y17, 225Y17, 226Y19, 321Y15, or 721Y15, respectively.

This Handbook serves as the Summary Plan Descriptions ("SPDs") for the Benefit Plans (as defined below) as of January 1, 2021. It completely replaces any SPDs or summaries of material modifications that you have previously received with respect to the benefits described herein. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supersede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD or any oral communication, on the one hand, and an official plan document, on the other hand. The 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 a portion thereof, also covers the following classes of employees or former employees of NiSource Inc. ("NiSource" or the "Company") or an affiliate of the Company (an "Employer," which term includes NIPSCO) that has adopted, or is deemed to have adopted, such coverage, as provided in the plan documents governing such coverage,, although benefits for such classes of employees or former 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

The Company offers eligible retired employees and their eligible dependents the following coverages in accordance with the terms of the applicable benefit plans (identified below and sometimes collectively referred to as the "Benefit Plans" and individually as a "Benefit Plan"). *(Details of each Benefit Plan can be found in the*

individual Benefit Plan sections of this Handbook.)

For eligible retired employees and/or their eligible dependents who are under age 65:

- Medical and Prescription Drug Coverage (NiSource Consolidated Flex Medical Plan – referred to as the "Pre-65 Retiree Medical Plan")
- Life Insurance Coverage (Northern Indiana Public Service Company Employee Life Insurance Plan – referred to as the "Retiree Life Insurance Plan")

For eligible retired employees and/or their eligible dependents who are age 65 or over:

- Medical Coverage (NIPSCO Medicare Supplement Option under the NiSource Post-65 Retiree Medical Plan –referred to as the "Post-65 Retiree Medical Plan")
- Life Insurance Coverage (Northern Indiana Public Service Company Employee Life Insurance Plan – referred to as the "Retiree Life Insurance Plan")

Accessing Benefits Information

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

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

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

Definitions

Definitions Applicable to Retiree Medical Plans

Unless otherwise defined in the applicable individual Benefit Plan section of this Handbook, as used in this **Benefits Program Overview**, and for purposes of the Pre-65 Retiree Medical Plan and the Post-65 Retiree Medical Plan (each individually a "Plan" or "Retiree Medical Plan"), the following terms when used in this Handbook shall have the following meanings:

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

"Child" means a person who is

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

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

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

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

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

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

"Defined Dollar Years of Service" means the total number of Years of Service at retirement, rounded up to the nearest whole number, earned by a 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 NiSource or an affiliate in which the former employee accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan.

"**Experimental or Investigational**" means services, equipment, supplies, devices, treatments, procedures or drugs that are not Medically Necessary or that are investigational or experimental for the diagnosis or treatment of any Sickness or Injury for which any of such items are prescribed. Experimental or Investigational items include, without limitation, items that (1) are not accepted as standard medical treatment by physicians practicing the applicable medical specialty; (2) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; (3) have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal departments of Health and Human Services and the Food and Drug Administration, or any comparable state governmental agency; (4) have not been approved by the Federal Centers for Medicare and Medicaid Services for reimbursement under Medicare Title XVIII; or (5) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

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

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

"In-Network Provider" has the meaning given the term in the section of the Pre-65 Retiree Medical Plan SPD entitled "Maximum Allowed Amount."

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

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

and (8) not otherwise subject to an exclusion. Determinations of medical necessity or what is "Medically Necessary" are made by the Plan Administrator in its sole and absolute discretion.

"Out-of-Network Provider" has the meaning given the term in the section of the Pre-65 Retiree Medical Plan SPD entitled "Maximum Allowed Amount."

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

"Pre-65 Retiree" means a Retiree who has not attained age 65.

"Post-65 Retiree" means a Retiree who has attained age 65.

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

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

"Spouse" means a person who is treated as your spouse under the Internal Revenue Code. ***Please Note:*** See "Eligibility under the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan" below for limited circumstances under which a former Spouse or a Spouse from whom you are legally separated may be eligible for pre-65 retiree medical coverage under a policy of health insurance or pursuant to a contract with a health maintenance organization.

Definitions Applicable to Retiree Medical Plans and Retiree Life Insurance Plan

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

"Eligibility Years of Service" means the total number of years of active employment with NiSource or an affiliate that you completed, as calculated as of the date of your retirement and as determined by the Plan Administrator in its sole and absolute discretion.

"Employer" means the Company, or an affiliate of the Company, including NIPSCO, as the context requires. As the context requires, the term also refers to Kokomo and NIFL, each of which previously merged into NIPSCO.

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

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

notice; provided, however, that such period shall be subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A, and to such other limitations or guidance that may be issued by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, or Department of the Treasury.

"Participating Employer" means, with respect to any Benefit Plan, the Company, NIPSCO, or any other affiliate of the Company that has adopted, or is deemed to have adopted, the Benefit Plan.

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

"Retiree" means

(a) a former full-time employee of NIPSCO represented by a NIPSCO USW Union who was (1) hired or rehired before June 1, 2004 and who retired on or after February 1, 2017, (2) hired or rehired on or after June 1, 2004 and before June 1, 2009 and who retired on or after February 1, 2017, or (3) hired or rehired on or after June 1, 2009 and who retired on or after June 1, 2019, and whose retirement was in accordance with a plan or procedure adopted by NIPSCO after such former employee attained age 55 and 10 Eligibility Years of Service, or was in accordance with such other plan or procedure as may have been adopted in writing by NIPSCO; or

(b) a former full-time employee of

(1) Kokomo, and subsequently of NIPSCO after the merger of Kokomo into NIPSCO, represented immediately prior to retirement by a NIPSCO USW Union, or

(2) NIFL, and subsequently of NIPSCO after the merger of NIFL into NIPSCO, represented immediately prior to retirement by a NIPSCO USW Union,

who was hired before January 1, 2012, and who retired on or after January 1, 2015, and whose retirement was in accordance with a plan or procedure adopted by NIPSCO after such former employee attained age 55 and 10 Eligibility Years of Service, or was in accordance with such other plan or procedure as may have been adopted in writing by NIPSCO.

Notwithstanding the foregoing, the term "Retiree" shall not include a person the Plan Administrator determines, in its discretion, belongs to a Retiree Benefit Program other than Retiree Benefit Programs 221Y17, 225Y17, 226Y19, 321Y15, or 721Y15. (Retiree Benefit Programs are groupings, established by the Plan Administrator for recordkeeping purposes, of similarly situated retirees who are entitled to retiree medical benefits or retiree life insurance benefits at retirement.)

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 participate in the Benefit Plans when and to the extent provided under the applicable Benefit Plan. Generally, you and your eligible dependents will be eligible to participate in the Benefit Plans on the date of your retirement.

Please Note: A Retiree who is rehired by an Employer other than NIPSCO, or who is rehired by NIPSCO other than as an Employee represented by a USW Union, shall lose eligibility for coverage as a Retiree under the Retiree Medical Plans and the Retiree Life Insurance Plan (and shall not be eligible for such coverage upon his or her subsequent retirement), but may be eligible for coverage under the NiSource Consolidated Flex Medical Plan and the NiSource Life Insurance Plan while an employee, subject to the terms and conditions for employee coverage under those Benefit Plans. *Please contact the Benefits Source at **1-888-640-3320** to speak to a service representative if you have any questions concerning your eligibility for retiree medical or retiree life insurance benefits in the event you are rehired as an employee.*

***Please Note**:* It is your responsibility to advise the Benefits Source when a person is no longer eligible for coverage as a dependent under a Benefit Plan. Any amounts paid by a Benefit Plan on behalf of a person who is no longer an eligible dependent will be required to be repaid to the plan. *Enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under a Benefit Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits and required repayment of any ineligible expenses.* Also, enrollment of a dependent under a Benefit Plan may be denied or revoked if you fail to provide information or evidence reasonably requested by the Plan Administrator or its designee concerning the dependent's eligibility for coverage under the Plan.

Eligibility under the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan

Pre-65 Retirees are eligible to participate in the Pre-65 Retiree Medical Plan. Post-65 Retirees are eligible to participate in the Post-65 Retiree Medical Plan.

If you are a Pre-65 Retiree participating in the Pre-65 Retiree Medical Plan or a Post-65 Retiree participating in the Post-65 Retiree Medical Plan, (a) you may cover your eligible dependents under the Pre-65 Retiree Medical Plan if they have not attained age 65, and (b) you may cover your eligible Spouse under the Post-65 Retiree Medical Plan if he or she has attained age 65.

Your eligible dependents include:

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

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.

- With respect to Pre-65 Retiree Medical Plan coverage only, your child who is recognized under any court order, including a Qualified Medical Child Support Order recognized as being legally sufficient, as having a right to participate in the Plan as a dependent.

A child satisfies the dependency test for a particular Plan Year if you would be allowed a dependent exemption for such child in computing your federal taxable income for such year, even if the Code provides that the value of such exemption for a particular year is zero. Your child also satisfies the dependency test for a particular Plan Year if (1) such child receives over half of his or her support during the year from his or her parents and is in the custody of one or both parents for more than half of the year, (2) at least one parent would be allowed a dependent exemption for such child in computing such parent's federal taxable income for such year, and (3) the child's parents are divorced, legally separated under

a decree of divorce or separate maintenance, legally separated under a written separation agreement, or live apart at all times for the last six months of the year. In making these determinations, you may ignore the child's gross income for such year. You should consult a tax advisor if you have any questions about whether your child satisfies this dependency test.

*Please refer to the Benefits Source website, mysourceforhr.com, or call the Benefits Source automated telephone system at **1-888-640-3320** if you are unsure of whether you are eligible to participate in the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan.*

Eligibility under the Retiree Life Insurance Plan

As a Retiree, you are eligible to participate in the Retiree Life Insurance Plan.

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

Enrollment

General Information Concerning Enrollment

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

You are automatically enrolled for EAP/Work Life/Legal & Financial Services coverage (even if you elect the No Coverage Option for retiree medical coverage) upon the date you become eligible for such coverage.

You are automatically enrolled for retiree term life insurance coverage upon the date you become eligible for such coverage.

To enroll in retiree medical coverage, you must log on to the Benefits Source website, mysourceforhr.com, or call the Benefits Source at **1-888-640-3320.**

Enrollment in the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan

Provided you meet the eligibility requirements, as described in the "*Eligibility*" section above, you and your eligible dependents can participate in the Pre-65 Retiree Medical Plan and/or Post-65 Retiree Medical Plan, as applicable, if you properly enroll or are deemed to have enrolled.

For the Pre-65 Retiree Medical Plan, if you are a newly eligible retiree, you must enroll yourself and any eligible dependents in retiree medical coverage no later than 31 days after the date of your retirement.

For the Post-65 Retiree Medical Plan, you must enroll yourself and your Spouse, if eligible, before 31 days after the later of (i) the date of your retirement, and (ii) the date you attain age 65.

In general, once you enroll for (or decline) coverage in the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan, your elections stay in effect for the entire Plan Year and can only be changed during annual open enrollment. However, if you experience a qualified life event, you may enroll or change existing elections during the year in certain circumstances. Please see the *"Changing and Continuing Elections"* section of this **Benefits Program Overview** for further details. Also, you may select the "No Coverage" option at any time; however once you select this option, you may select another coverage option only at annual enrollment or in connection with a qualified life event that would permit such change.

Enrollment materials will automatically be sent to you upon your retirement and you will have 31 days after the date you first become eligible for retiree medical coverage to mail your medical plan election form or otherwise to complete enrollment. Provided you have timely elected coverage, your Benefit Plan enrollment will be effective on the first day of the month in which you retire, or in the case of a Pre-65 Retiree who attains age 65, your enrollment in the Post-65 Retiree Medical Plan will be effective as of the first day of the month in which you attain age 65. (If you are a Pre-65 Retiree who attains age

65 on the first day of a month, your enrollment in the Post-65 Retiree Medical Plan will be effective as of the first day of the month immediately preceding the month in which you attain age 65.) If you fail to enroll in retiree medical coverage at your first opportunity to enroll, your next opportunity to enroll will be in conjunction with the next annual enrollment or upon the occurrence of a qualified life event.

In the event you fail to enroll in retiree medical coverage at the time of your retirement (including by failing to elect the No Coverage Option), you fail to enroll in the Post-65 Retiree Medical Plan upon attaining age 65 after your retirement, or you fail to enroll your eligible Spouse in the Post-65 Retiree Medical Plan when he or she attains age 65, the following will take place:

- If you or an eligible dependent are under age 65 you will be deemed to have elected the coverage option and category of coverage under the Pre-65 Retiree Medical Plan that was in place for you and/or your eligible dependent(s) on the date you retired;
- If you are age 65 or over, you will not be covered by any plan for retiree medical benefits as of the date of your retirement or the date you attain age 65; and
- If your eligible Spouse is age 65 or over, he or she will not be covered by any plan for retiree medical benefits as of the date he or she attains age 65.

If you are a current Retiree enrolled in retiree medical coverage, and you do not make changes during the annual enrollment process, your current benefits, if available, will be maintained.

Please Note:

If you do not enroll in the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical 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.

Enrollment in the Retiree Life Insurance Plan

Provided eligibility requirements are met, as described in the section above entitled "*Eligibility under the Retiree Life Insurance Plan,*" you will be enrolled in the Basic Retiree Term Life Coverage Option upon the date of your retirement

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

If your covered dependent becomes employed by an Employer and either timely elects medical coverage or makes no medical coverage election and is thereby deemed to have elected medical coverage under the NiSource Consolidated Flex Medical Plan, you will be deemed to have requested that coverage for such dependent under a Retiree Medical Plan be dropped.

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

Enrollment Pursuant to a Qualified Medical Child Support Order

The Pre-65 Retiree Medical Plan also provides group health plan coverage for your eligible child 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 Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child.

You may obtain, without charge, a copy of the Pre-65 Retiree Medical Plan's QMCSO procedures from the Company.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the Benefit Plans. Except as noted below, 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.

In the event your current plan coverage is not available and you fail to elect coverage under another plan or option that is offered to you, you will be deemed to have elected the default coverage, if applicable. Please see the section above entitled "Enrollment in the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan" for further details.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan at your home address.

Your ID card 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.

Defined Dollar Subsidy for Retiree Medical Coverage

Pre-65 Retirees, Post-65 Retirees, and their eligible Spouses are entitled to receive an annual defined dollar subsidy ("Defined Dollar Subsidy") to be credited toward the cost of their retiree medical coverage under a Retiree Medical Plan.

The Defined Dollar Subsidy is determined by multiplying your Defined Dollar Years of Service by a fixed dollar amount.

If you and your Spouse are both enrolled in a Retiree Medical Plan, and if you die prior to your Spouse, your surviving Spouse may receive a Defined Dollar Subsidy, to be credited toward the cost of coverage under a Retiree Medical Plan, in the amount to which you would have been entitled had you survived and were the same age as your Spouse.

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 – Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan

Coverage Begins

Generally, coverage under the Pre-65 Retiree Medical Plan may become effective on the later of (1) the date you retire, (2) the first day of the following Plan Year for eligible Retirees who enroll during the annual enrollment period, (3) the date the Plan approves your enrollment based upon a qualified life event, and (4) the date you properly enroll. Coverage for your eligible dependent under the Pre-65 Retiree Medical Plan may become effective, if you properly

enroll him or her, (1) on the date your coverage becomes effective, (2) the first day of the following Plan Year if you enroll your eligible dependent during the annual enrollment period, or (3) on the date the Plan approves his or her enrollment based upon a qualified life event.

Coverage for you under the Post-65 Retiree Medical Plan may become effective on the later of (1) the date you retire, (2) the first day of the month in which you attain age 65 (or on the first day of the immediately preceding month, if you attain age 65 on the first day of the month), and (3) the date you properly enroll. Coverage for your eligible Spouse under the Post-65 Retiree Medical Plan may become effective, if you properly enroll him or her, (1) the date your coverage becomes effective, (2) the first day of the following Plan Year if you enroll your eligible Spouse during the annual enrollment period, or (3) the date the Plan approves his or her enrollment based upon a qualified life event.

Coverage Ends

Except in the case of your death (in which case coverage ends on the date of your death) or in the case of a divorce or legal separation (in which case coverage for your Spouse ends on the date of divorce or legal separation), coverage under the Pre-65 Retiree Medical Plan or the Post-65 Retiree Medical 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 a Retiree;
- The date a Retiree is no longer eligible for coverage under the Plan, including without limitation as a result of being rehired by an Employer;
- The last date for which any required contribution was made;
- The date the covered Retiree provides notice to the Company of his or her intent to terminate coverage; or
- With respect to the Pre-65 Retiree Medical Plan, the date a Pre-65 Retiree attains age 65.

A dependent's eligibility generally ends on the earliest of the following dates:

- The date the Retiree's coverage ends;
- The last date for which any required contributions for the dependent's coverage was made;
- The date the covered Retiree provides notice to the Company of his or her intent to terminate coverage for such dependent;
- With respect to a Spouse who becomes divorced or legally separated from a Retiree, the date of divorce or legal separation; or
- The end of the month following the date a dependent no longer qualifies as a dependent.

Notwithstanding the foregoing, if coverage for you or your dependents is terminated during a Plan Year for failure to pay required contributions for coverage, you may apply to the NiSource Benefits Department during the same Plan Year to reinstate coverage retroactive to the date of termination. Your application must be in writing and must describe the extenuating circumstances that resulted in your missed payment. The Benefits Department, in its sole and absolute discretion, will determine whether there are sufficient grounds for reinstating coverage. If the Benefits Department makes a favorable determination, you must repay any missed premiums before the end of the Plan Year and before coverage will be reinstated.

Also, notwithstanding the foregoing, if your dependent experiences a COBRA qualifying event, EAP/Work Life/Legal & Financial Services coverage will end the day after the expiration of the maximum COBRA continuation coverage period that would otherwise apply to such dependent, if COBRA were to apply to EAP/Work Life/Legal & Financial Services coverage. For a description of COBRA qualifying events, please see the "COBRA" subsection of the *"Continuation of Coverage"* section of this **Benefits Program Overview**

Please see the *"Continuation of Coverage"* section of this **Benefits Program Overview** for circumstances under which your coverage under the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan may be continued beyond the periods described above.

When Coverage Begins and Ends – Retiree Life Insurance Plan

Coverage Begins

Provided you have satisfied the eligibility and enrollment requirements described above, coverage under the Basic Retiree Term Life Coverage Option may generally become effective upon your retirement from an Employer.

Coverage Ends

Your coverage under the Basic Retiree Term Life Coverage Option will end when the first of these occurs:

- The date as of which the Plan is terminated;
- The date the Group Contract (as defined in the Retiree Life Insurance SPD) is canceled, or with respect to a particular Life Insurance Coverage Option, the date such 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 are no longer eligible for coverage under the Plan as a member of an eligible class, including without limitation as a result of being rehired by an Employer;

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, you may make or change certain Retiree Medical Plan elections during the Plan Year under certain limited circumstances, referred to herein as "qualified life events." For example, you may change certain elections if you experience a "qualified status change" that affects your, your Spouse's, or your dependent's eligibility for benefits under the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan. A "qualified status change" is one type of qualified life event. Examples of qualified status changes and a description of other qualified life events are set forth below.

You must contact a customer service associate at the Benefits Source at **1-888-640-3320** to request a change in election within **31 days** of the date of the qualified life event (or **60 days**, in the case of certain HIPAA special enrollment events discussed below). ***Please note, however, that the 31-day period will be extended for a limited period of time. More specifically, the portion of the Outbreak Period (defined above) that is before January 1, 2021 will be disregarded in calculating the 31-day period. Also, for qualified life events that are also HIPAA special enrollment events under the Pre-65 Retiree Medical Plan, the Outbreak Period both before and after January 1, 2021 will be disregarded.***

In connection with any requested election change, you may be required to provide certifications or other evidence requested by the Company, the Plan Administrator, or the Claims Administrator.

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).
- Your dependent becomes eligible for coverage.
- 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:

In general, if you do not request a change in your Retiree Medical Plan 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. Please note the special rules discussed in this section for election changes under the Pre-65 Retiree Medical Plan based upon HIPAA special enrollment events, as well as the impact of the Outbreak Period on the timeframes for making benefit election changes based upon those events.

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.
- With respect to the Pre-65 Retiree Medical Plan only, you qualify for special enrollment during the year under 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 (including coverage purchased through a government exchange or other health insurance coverage purchased in the individual market) 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 Pre-65 Retiree Medical Plan, under such a Medicaid plan or State child health plan. *Please note: For an event described in item (3), your special enrollment period will be 60 days, not 31 days.* ***Please note, however, that the Outbreak Period (defined above) will be disregarded in calculating the 31-day or 60-day period permitted by HIPAA special enrollment provisions).***
- The Pre-65 Retiree Medical 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 that Plan.
- You, your Spouse or dependent lose coverage under any group health coverage sponsored by a governmental or educational institution, in which case you may be able to elect coverage under the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan, as applicable.
- With respect to accident or health plan coverage, you, your Spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.

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

Notwithstanding the foregoing or any other provision of this Handbook, if you are covered under the Pre-65 Retiree Medical Plan or the Post-65 Retiree Medical Plan, you may drop your coverage or reduce the number of dependents covered under a Retiree Medical Plan at any time. However, once you drop your coverage or drop coverage for one or more of your dependents, you will not be able to enroll again in coverage until the next annual enrollment period or until you experience a qualified life event that would permit enrollment.

Coordination of Benefits (COB)

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

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, a Retiree Medical Plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator.

The "Birthday Rule"

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

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

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

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

How Coordination Works With Medicare

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

You should notify a Benefits Source customer service associate if you start Medicare benefits. The way medical coverage under the Benefit Plans coordinates with Medicare depends upon whether you are in "current employment status," as that term is defined in Medicare regulations, and upon a covered person's age and whether he or she is receiving Social Security disability benefits. A retiree generally is not in current employment status. The discussion below assumes that a retiree covered under a Retiree Medical Plan is not in current employment status for purposes of Medicare. However, if you believe you have current employment status for purposes of Medicare regulations, you should contact the Benefits Source at **1-888-640-3320**.

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

If you are covered under a Retiree Medical Plan but are no longer considered by Medicare to be in "current employment status," and if you, your covered Spouse or your other covered dependents are Medicare-eligible, then Medicare will generally be treated by the Retiree Medical Plan as the primary payor for the covered person who is Medicare-eligible, regardless of the covered person's age and, except for Medicare Part D

prescription drug coverage, regardless of whether he or she has enrolled in Medicare or any part thereof. If your covered Spouse or other covered dependent is not Medicare-eligible, the Retiree Medical Plan will be treated as the primary payor with respect to such person's benefits.

Please Note:

End-Stage Renal Disease. If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is not already paying as primary, the Pre-65 Retiree Medical Plan and the Post-65 Retiree Medical Plan continue to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

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

Please Note:

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

You are responsible for notifying the Claims Administrator if you, your Spouse or your other dependents become Medicare-eligible.

Please Note:

If you are covered under a Retiree Medical Plan and you, your covered Spouse or your other covered dependents become eligible for Medicare on account of age or receipt of Social Security disability benefits, it is important that you contact the Benefits Source to ensure it has this information, as it may impact how your NiSource medical benefits are processed through coordination with Medicare. You may contact the Benefits Source at **1-888-640-3320**.

How Coordination of Benefits Work with Medicare Part D

If you have prescription drug coverage under the Pre-65 Retiree 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 certain claims and appeals to the applicable Claims Administrator (listed in the "*General Program Information*" found at the end of each Benefit Plan section, or SPD, in this Handbook). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

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

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

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

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

For details regarding how to file a claim and the claim denial and appeal processes for each of the Benefit Plans, please see below or the individual Benefit Plan sections, or SPDs, in this Handbook. Any claim relating to whether you meet the requirements for eligibility under the terms of an applicable Benefit Plan should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the SPD for such Benefit Plan.

Discretion and Authority of Plan Administrator and Claims Administrator

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

Legal Action

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

Claim Determination and Appeal Process – Pre-65 Retiree Medical Plan

The claim determination and appeal process described below applies to the Pre-65 Retiree Medical Plan. The term "Plan" as used in this section refers to the Pre-65 Retiree Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Pre-65 Retiree Medical Plan. (Note that there may be more than one claims administrator for the Plan.)

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

Claims Administrator's determination. In addition, you will be notified of any adverse benefit determination that results in a rescission of your coverage.

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

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

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

The Plan Administrator or its designee may decide claims (i) that involve a rescission of coverage, (ii) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (iii) for which a Claims Administrator has not been delegated authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a rescission of coverage, a determination of your eligibility under the Plan, or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) a rescission of coverage, (ii) whether you meet the requirements for eligibility under the Pre-65 Retiree Medical Plan, or (iii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Pre-65 Retiree Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

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

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

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

Post-Service Claims

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

If you submit a post-service claim, you will receive a written notice of the Claims

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

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

Urgent Care Claims

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

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

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

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

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

If You Have Questions

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

Concurrent Care Claims

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

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

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

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

Full and Fair Review

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

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

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

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

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

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

Mandatory First-Level Internal Appeal to Claims Administrator

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

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Pre-65 Retiree Medical Plan.

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

Expedited Review for Urgent Care Claims

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

- Your name;
- The date(s) of the medical service;
- The specific medical condition or symptom;
- The provider's name

- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

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

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

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

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

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

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

Second-Level Internal Appeal to the Claims Administrator

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

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

The Plan waives any right to assert that you failed to exhaust administrative remedies because you did not request a voluntary second-level internal appeal. The 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 Plan will have no effect on your right to any other benefits under the Plan.

Your request for review should be sent to the Claims Administrator at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Pre-65 Retiree Medical Plan.

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

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

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

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

Pre-Service Claims

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

Post-Service Claims

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

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

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

- Information sufficient to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reason or reasons for the adverse benefit determination;
- The specific Plan provisions on which the adverse benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement indicating your right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and
- To the extent required by applicable regulations, the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist you.

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

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

Voluntary External Review by Independent Review Organization

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

Standard External Review

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

If the Claims Administrator makes a final adverse benefit determination with respect to your mandatory first-level appeal or second-level appeal, as the case may be, or makes an adverse benefit determination under circumstances in which you are not required to exhaust the Plan's internal appeals process, you or your duly authorized representative may file a request for an external review under Federal law within four months of the date you received notice of an adverse benefit determination or final internal adverse benefit determination. Your request

must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to resubmit information that you submitted for your initial claim or internal appeal. However, you are encouraged to submit any additional information you believe is important for review.

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

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

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

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

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

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

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

- Your medical records;
- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- The opinion of the IRO's clinical reviewer or reviewers after considering the information above and applicable Federal guidance, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

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

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

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

Expedited External Review

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

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

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

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

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

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

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

Limitation of Actions and Venue

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

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

Claim Determination and Appeal Process – Post-65 Retiree Medical Plan

The claim determination and appeal process described below applies to the Post-65 Retiree Medical Plan. The term "Plan," as used in this section, refers to the Post-65 Retiree Medical Plan, and the term "Claims Administrator" refers to the applicable claims administrator appointed for the Plan. (Note that there may be more than one claims administrator for the Plan.)

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

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

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

The Plan Administrator or its designee may decide claims (i) that call for a determination of whether you meet the requirements for eligibility under the Plan, which determination may result in a denial, reduction, termination or failure to provide payment for a benefit, or (ii) for which a Claims Administrator has not been delegated

authority, or has not assumed authority, to decide. The Plan Administrator has delegated to the Company's Benefits Department authority to make these determinations. Solely with respect to claims involving a determination of your eligibility under the Plan or a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide, the term "Claims Administrator" used below shall refer to the Plan Administrator or its designee. Any claim relating to (i) whether you meet the requirements for eligibility under the Pre-65 Retiree Medical Plan, or (ii) a matter for which the Claims Administrator has not been delegated, or has not assumed, authority to decide should be submitted in writing to the Benefits Department of the Company at the address for the Plan Administrator set forth in the *General Program Information* section of the Post-65 Retiree Medical Plan SPD.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

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

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

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

Post-Service Claims

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

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

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

Urgent Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient, jeopardize the patient's ability to regain maximum function, or, in the opinion of the patient's doctor, with knowledge of the patient's medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is 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 will be notified of the specific information needed to complete the claim within 24 hours after the Claims Administrator receives your urgent care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

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

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

If You Have Questions

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

Concurrent Care Claims

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

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

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

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

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

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

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

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

benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

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

First-Level Appeal to Claims Administrator

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

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Post-65 Retiree Medical Plan.

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

Your written request should state why you think your claim should not have been denied. Your request also should 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 determination on review, will be transmitted between the Claims Administrator and you by telephone,

facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact the Claims Administrator and provide at least the following information:

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

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

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

If the Claims Administrator makes an 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.

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

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

Your request for review should be sent to the Claims Administrator for the Plan at the address for the Claims Administrator set forth in the section entitled "General Program Information" found in the individual SPD section for the Post-65 Retiree Medical Plan.

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

Your written request should state why you think your claim should not have been

denied. Your request also should include your name, the covered person's name and date of birth, the name of the provider of services, the name of your Employer, any denial letter you received, the claim number and any additional documents, information or comments you think may have a bearing on your claim.

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

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

Pre-Service Claims

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

Post-Service Claims

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

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

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

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

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

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

charge, or you will be informed that such explanation will be provided to you free of charge upon request.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

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

Claim Determination and Appeal Process – Retiree Life Insurance Plan

The claim determination and appeal process described below applies to the Retiree Life Insurance Plan. As used in this section, (i) the term "Claims Administrator" refers to Securian, (ii) a "claim for disability benefits" includes a claim for accelerated death benefits or for a waiver of premium, (iii) the term "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in a plan and, with respect to a claim for disability benefits, also means a rescission of disability coverage with respect to a claimant (regardless of whether, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and (iv) the term "rescission," with respect to a claim for disability benefits, means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

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

Consideration of Initial Claim

The Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 90 days after the receipt of your claim. This period may be extended by 90 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 90-day period.

Notwithstanding the foregoing, with respect to a claim for disability benefits, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after the receipt of your claim. This period may be extended for up to 30 days for matters beyond the control of the Plan if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claim Administrator expects to render its decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the

unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the Claims Administrator makes an adverse benefit determination with respect to your claim, you or your authorized representative will receive a written notice from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary, and
- a description of the Claims Administrator's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan,
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal to the Claims Administrator

If an adverse benefit determination is made with respect to your claim for benefits or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal the adverse benefit determination in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written adverse benefit determination or from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, and free of charge, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Claims Administrator, utilizing individuals who were not involved in the initial benefit determination and who are not the subordinates of such individuals. This review will not afford any deference to the initial benefit determination.

In connection with a claim for disability benefits, if the adverse benefit determination was based in whole or in part on a medical

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

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

The Claims Administrator shall make a determination on your claim appeal within a reasonable period of time, but not later than 60 days (45 days in the case of a claim for disability benefits) after the receipt of your appeal request. This period may be extended by up to an additional 60 days (45 days in the case of a claim for disability benefits)if the Claims Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Administrator expects to render a decision shall be furnished to you within the initial 60-day period (45-day period in the case of a claim for disability benefits). However, in the case of a claim for disability benefits, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If an adverse benefit determination is made with respect to your claim on appeal, you will receive a written notification from the Claims Administrator of the adverse benefit determination. The notice will be written in a manner calculated to be understood by you and shall include:

- the specific reason(s) for the adverse benefit determination,
- references to the specific Plan provisions on which the adverse benefit determination was based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and to make copies of, all records, documents and other information relevant to your benefit claim,
- a statement describing any voluntary appeals procedures offered by the Plan, and your right to obtain information about such procedures, and
- a statement of your right to bring a civil action under section 502(a) of ERISA following completion of the appeals process.

In addition, in the case of an adverse benefit determination with respect to a claim for disability benefits, the notice shall include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views that you presented to the Plan of health care professionals treating you and of vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you that was made by the Social Security Administration and that you presented to the Plan;

- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- a statement indicating (A) that any civil action under section 502(a) of ERISA must be brought not later than three years after the date such claim was incurred, and (B) the calendar date upon which such limitations period expires.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Discretion and Authority of Claims Administrator

The Claims Administrator has the sole discretion to interpret the terms of the benefits provisions of the Plan, to make factual findings, and to determine eligibility for benefits. A benefits-related decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan shall be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.

The Claims Administrator has the right to recover any overpayments for whatever reason, including due to (i) fraud and (ii) any error the Claims Administrator makes in processing a claim. You must reimburse the Claims Administrator in full for any overpayments. The Claims Administrator will determine the method by which the repayment is to be made. The Claims Administrator will not recover more money than the amount it paid you.

Limitation of Actions and Venue

No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law.

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

Continuation of Coverage

COBRA

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Pre-65 Retiree Medical Plan and under the Post-65 Retiree Medical Plan (each of the foregoing a "Plan" for purposes of this COBRA section). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For a discussion of special survivor coverage that may extend coverage under the Pre-65 Retiree Medical Plan and the Post-65 Retiree Medical Plan beyond the maximum period of COBRA continuation coverage, see the section below entitled *"Survivor Coverage."* COBRA continuation coverage does not apply to EAP/Work Life/Legal & Financial Services coverage.

In the event you are eligible for COBRA continuation coverage, there may be other coverage options for you and your family as well. With the advent of health care reform, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible (but not enrolled) for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan

for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Please Note: ***Notwithstanding the timeframes described below, you may disregard the Outbreak Period in determining (i) the 60-day election period for COBRA continuation coverage, (ii) the date for making COBRA premium payments, and (iii) the date for notifying the Plan of a qualifying event.***

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse (if he or she is treated as a spouse under the Code), and your dependent children could become qualified beneficiaries on account of coverage under a Plan if coverage under such Plan is lost because of a qualifying event. Under each Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). These costs are subject to change.

You must elect COBRA during your COBRA election period. Your COBRA election period begins on the date of your qualifying event and ends on the date that is 60 days after the later of (i) the date coverage would have stopped due to the qualifying event, or (ii) the date the qualified beneficiary is sent notice of the right to continue coverage under COBRA.

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 45 days of the monthly due date, COBRA coverage will be cancelled.

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;
- 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;
- 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."

With respect to coverage under a Plan for Retirees, sometimes the filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to NiSource or one of its affiliates, and that bankruptcy results in your loss of coverage under the Plan, you will become a qualified beneficiary with respect to the bankruptcy. Your Spouse, surviving spouse, and dependent children will also become qualified beneficiaries if they were covered under the Plan on the day immediately preceding the commencement of the bankruptcy proceeding and the proceeding resulted in their loss of coverage.

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 your death, the

commencement of a proceeding in bankruptcy with respect to your Employer (in the case of loss of retiree coverage), or your becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the latest of (i) the date qualifying event occurs, or (ii) the date on which the dependent loses (or would lose coverage) as a result of the qualifying event. This notice must be provided to the Benefits Source by calling the Benefits Source at 1-888-640-3320, or in the case of a notice of divorce or legal separation, by visiting the Benefits Source website at mysourceforhr.com.

Any such notice must provide the date of divorce or legal separation or the date a dependent child lost eligibility for coverage, as the case may be, and must indicate that the notice is being provided for purposes of obtaining COBRA continuation coverage. If notice is not provided within the 60-day period, you and your dependent will not be eligible for COBRA continuation coverage.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. 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 an Employer's bankruptcy, COBRA continuation coverage for you ends upon your death and coverage for a qualified beneficiary who is your Spouse or dependent child ends on the earlier of the date of the qualified beneficiary's death or three years after your death.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above, 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 a Plan 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).
- The date such qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) the qualified beneficiary pursuant to applicable law. Please see the "*Coordination with HIPAA and Affordable Care Act*" section below for additional information.

Coordination with HIPAA and Affordable Care Act

Under COBRA, your rights to continue coverage terminate if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated before the maximum coverage period. HIPAA and the Affordable Care Act limit the extent

to which certain group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to you because of HIPAA or the Affordable Care Act, your entitlement to COBRA continuation coverage under the Pre-65 Retiree Medical Plan will terminate before the maximum coverage period.

Questions

Questions concerning the Plans or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at **dol.gov/ebsa** (addresses and phone numbers of Regional and District Offices are available through EBSA's website).

If you have questions about enrolling in COBRA, contact the Benefits Source at **1-888-640-3320**.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, contact the Benefits Source at **1-888-640-3320**.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Survivor Coverage

In the event of a covered Retiree's death within 30 days preceding, or at any time on or after, May 1, 2010, if COBRA continuation coverage under a Retiree Medical Plan has been elected and has not terminated prior to the maximum continuation coverage period (36 months) for such Retiree's surviving dependents who are covered under the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan on the date of that Retiree's death, then coverage for such dependents may continue beyond such 36-month period until the earlier of (i) the date the Retiree's surviving spouse dies, (ii) the last day of the month in which the Retiree's surviving spouse remarries or enters into a domestic partnership or civil union with another person, (iii) the last date for which any required contribution was made, (iv) with respect to a dependent child, the last day of the month in which the child no longer qualifies as a dependent, (v) with respect to any dependent covered under the Pre-65 Retiree Medical Plan, the date such dependent reaches age 65, and (vi) the date the Employer from whom the Retiree retired from employment ceases to be a "related employer," as defined in the Pre-65 Retiree Medical Plan or the Post-65 Retiree Medical Plan.

If medical coverage under the NiSource Consolidated Flex Medical Plan ends for an active employee's dependent because of such employee's death within thirty days preceding, or at any time on or after May 1, 2010, and if such employee would have satisfied the conditions for being a Retiree had he or she retired from service with an Employer on the day immediately preceding his or her death, then solely for the purpose of COBRA continuation coverage and survivor coverage for any surviving dependents covered under the NiSource Consolidated Flex Medical Plan at the time of the employee's death, the employee will be deemed to have (i) retired from service with an Employer on the day immediately preceding his or her death (the "Deemed Retirement Date") and be a "Deemed Retiree", (ii) enrolled in retiree medical coverage on the Deemed Retirement Date, and (iii) enrolled each such surviving dependent in coverage under either the Pre-65 Retiree Medical Plan (in the coverage option in which the dependent was enrolled immediately prior to the Deemed Retirement Date), with respect to surviving dependents who have not attained age 65, or, with respect to a surviving spouse who has attained age 65, the Post-65 Retiree Medical Plan (in an available coverage option selected by the surviving spouse), as applicable. An eligible surviving dependent of a Deemed Retiree shall be entitled to survivor coverage in accordance with the terms and conditions described in the immediately preceding paragraph. An eligible surviving dependent

of a Deemed Retiree who has not attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Pre-65 Retiree Medical Plan. An eligible surviving spouse of a Deemed Retiree who has attained age 65 as of the Deemed Retirement Date will be entitled to survivor coverage under the Post-65 Retiree Medical Plan.

If survivor coverage under the Pre-65 Retiree Medical Plan will end for a surviving spouse solely on account of his or her attaining age 65, such dependent may continue survivor coverage under the Post-65 Retiree Medical Plan by enrolling in such Plan and by selecting an available post-65 retiree medical coverage option on or before attaining age 65. Such survivor coverage shall be subject to the terms and conditions set forth in the first paragraph of this section entitled "Survivor Coverage."

If a surviving dependent's COBRA continuation coverage has terminated for any reason prior to the expiration of the maximum COBRA continuation coverage period or if survivor coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason, such dependent may not reenroll in coverage. Notwithstanding the preceding sentence, if coverage for a surviving dependent is terminated during a Plan Year for failure to pay required contributions for coverage, the dependent may apply to the NiSource Benefits Department during the same Plan Year to reinstate coverage retroactive to the date of termination. The dependent's application must be in writing and must describe the extenuating circumstances that resulted in his or her missed payment. The Benefits Department, in its sole and absolute discretion, will determine whether there are sufficient grounds for reinstating coverage. If the Benefits Department makes a favorable determination, the dependent must repay any missed premiums before the end of the Plan Year and before coverage will be reinstated.

Additional Information

Assignment of Benefits

Except as required by applicable law, none of your rights or interests under the Pre-65 Retiree Medical Plan or the Post-65 Retiree Medical Plan (for purposes of this section only, each a "Plan") and no benefit payable under a Plan shall in any manner be alienated, sold, assigned or transferred, or be subject to any lien, pledge or encumbrance, in whole or in part, either directly or by operation of law or otherwise, including without limitation by execution, levy, garnishment, attachment, pledge, or bankruptcy, nor will any benefit payable under a Plan be liable for, or subject to, any obligation or liability you may have. Without limiting the generality of the foregoing, except as required by applicable law, you may not assign or transfer to any third party, including without limitation any person or institution providing medical care, treatment, services or supplies, the right to receive benefit payments under a Plan, or the right to pursue a claim, to appeal an adverse benefit determination or to maintain a cause of action under ERISA in respect of any benefit covered, alleged to be covered or denied under a Plan, and any such attempted assignment or transfer is void.

Nothing contained in a Plan or in this Handbook, nor any course of dealing, act or omission on the part of a Plan, its Plan Administrator or any Claim Administrator or other party, shall be construed to make a Plan liable to any third party to whom you may be liable for medical care, treatment, services or supplies. Although a Plan may, at your direction or otherwise, make payments directly to persons or institutions providing covered services under the Plan, such payment or direction does not constitute a transfer or assignment of benefits or of any other right or interest under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by a Plan shall constitute a complete discharge of the Plan's obligation to you. Under no circumstances will any person or institution providing medical care, treatment, services or

supplies to you be deemed a participant or beneficiary under a Plan.

If you attempt to alienate, sell, transfer, assign, pledge or otherwise impede a benefit under a Plan or any part, or if by reason of your bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by you, then upon becoming aware of such attempted alienation, sale, transfer, assignment or pledge, the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate your interest in any such benefit and hold or apply it to or for your benefit or the benefit of your dependents, in a manner the Plan Administrator may deem proper.

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to a Sickness or 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 Sickness or Injury;
- The insurer or other indemnifier of the party or parties who caused the Sickness or Injury;
- A guarantor of the party or parties who caused the Sickness or 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 covered person's Sickness or Injury.

Benefits may also be payable under the applicable Benefit Plan in relation to the Sickness or 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 Sickness or 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. No covered person shall take any action to prejudice the applicable Benefit Plan's subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable Benefit Plan, provide all information and sign and return all documents or agreements deemed necessary or desirable by the Benefit Plan for it to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information, to comply with the obligations under such agreements or to cooperate fully with the applicable Benefit Plan in asserting its subrogation and recovery rights does not preclude the Benefit Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Benefit Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the applicable Benefit Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable Benefit Plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his

or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable Benefit Plan shall be held separately and in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable Benefit Plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable Benefit Plan to the extent of the Benefit Plan assets that are so held in trust.

A covered person and his or her legal representative shall place any and all funds recovered from an Other Party in a separate reserve account under the control of the covered person and/or his or her legal representative. As a condition of participating in the applicable Benefit Plan, a covered person and his or her legal representative shall agree that any funds received from an Other Party rightfully and in good conscience belong to the applicable Benefit Plan, and that such funds shall be held in a constructive trust until distributed in accordance with this Subrogation and Right of Recovery provision.

The applicable Benefit Plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the covered person (or his or her legal representative) receives or is entitled to receive from any source whatsoever, including without limitation any of the sources listed above. Such lien and priority right shall extend to the first proceeds of any such recovery in the possession of the covered person, his or her legal representative or any third party, who shall hold the same in trust for the benefit of the Benefit Plan. This lien and priority right will not exceed the lesser of:

- The amount of benefits paid by the applicable Benefit Plan for the Sickness or Injury, plus the amount of all future benefits that may become payable under the applicable Benefit Plan that result from the Sickness or 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 Sickness or 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 Sickness or 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 Retiree;
- The Retiree's covered dependent;
- The estate of any covered person; or
- 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 Retiree or a covered dependent, the Retiree or any other person or organization that received the payment must refund the applicable Benefit Plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the Benefit Plan; or
- Was paid by a source other than the Benefit Plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *See the "Subrogation and Right of Recovery"* subsection for further details.

If you or the person or organization that was paid does not refund the full amount, the Benefit Plan may reduce the amount of any future benefits payable.

Provider Networks

Certain of the Benefit Plans make use of provider networks. As a general matter, benefit coverage may be greater and your out-of-pocket expenses may be lower if you use an In-Network Provider rather than an Out-of-Network Provider. For the Pre-65 Retiree Medical Plan and the Post-65 Retiree Medical Plan, provider lists may be obtained, without charge, at **anthem.com**, or by contacting an Anthem customer service associate at the number on the back of your ID card.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans' documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the Plan Privacy Official, Security Official, members of the Committee, persons specifically designated in the Plans and any other persons properly designated by one of the foregoing shall have access to Protected Health Information created under the Plans. Access to and use of

Protected Health Information by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Committee have retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

HIPAA Nondiscrimination

Notwithstanding any other provision of this Handbook, to the extent the Pre-65 Retiree Medical Plan generally provides benefits for a type of injury, benefits otherwise provided for treatment of the injury will not be denied if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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 any Employer. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Committee may amend the Benefit Plans at any time. In addition, (i) the Director, Benefits, of the Company, or an employee of the Company or its affiliates succeeding to the duties and responsibilities of such person, may amend the Benefit Plans at any time, if such amendments are required by applicable law or regulations, and (ii) the Senior Vice President and Chief Human Resources Officer of the Company and the Director, Benefits of the Company (or officers or employees of the Company or its affiliates succeeding to the duties and responsibilities of such persons) may amend the Benefit Plans or adopt amendments to, or guidelines with respect to the administration of, the Benefit Plans, and may take such other actions with respect to the Benefit Plans, as such persons deem necessary or desirable in response to the health emergency created by the COVID-19 virus or to any other similar health emergency and in response to the effect of any such emergency upon the Benefit Plans or the participants thereunder. The Committee reserves the right to terminate any Benefit Plan at any time without the consent of, or advance notice to, you or your covered dependents.

Named Fiduciary and Plan Administrator

The Committee is the "Named Fiduciary" and "Plan Administrator" of each Benefit Plan as defined in ERISA, and, as such, has authority to control and manage the operation and administration of the Benefit Plans. See also the "Definitions" section of this Benefits Program Overview for the definition of "Plan Administrator."

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the Benefit Plans, including determinations of eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Benefit Plans.

Without limiting the generality of the foregoing, the Plan Administrator or its delegate has full discretionary authority to: interpret the Benefit Plans and construe the Benefit Plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise

all of the power and authority contemplated by ERISA and the Code with respect to the Benefit Plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Benefit Plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the Benefit Plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Committee has delegated certain authority to the NiSource Benefits Department, to insurers, and to third party administrators or Claims Administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrators, to the NiSource Benefits Department or to insurers the discretionary authority to:

- Make decisions regarding the interpretation or application of Benefit Plan provisions;
- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Benefit Plans;
- Make claims determinations under the Benefit Plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the Benefit Plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the Benefit Plans, or portions thereof, that are self-insured, the Committee has retained one or more Claims Administrator to provide claims payment and other administrative services to such plans. Each Claims Administrator has full discretionary authority to decide claims and appeals for the claims it administers. However, even though a Retiree may receive a benefit check from a Claims Administrator, the Company, a Participating Employer or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although a Claims Administrator may have insurance coverage as part of its business, a Claims Administrator is not an insurer in relation to the Benefit Plans, or portions thereof, that are self-insured. The self-insured portions of Benefit Plans are funded from the general assets of the Company or a Participating Employer, or from another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to fully insured Benefit Plans, the Claims Administrator is also the Plan's insurer and has full and absolute authority to decide claims and appeals by virtue of authority delegated by the Committee.

Claims Administrators are identified in the General Program Information section for each Benefit Plan and are subject to change from time to time.

Statement of ERISA Rights

As a participant in a Benefit Plan maintained by NiSource Inc., you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Benefit Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Benefit Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Benefit Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan

Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Benefit Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for you, your Spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Benefit Plan documents or the latest annual report from the Benefit Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all required administrative appeals. In addition, if you disagree with the Benefit Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Benefit Plan fiduciaries misuse the Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

Assistance with Questions

Questions regarding the Benefit Plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Consolidated Flex Medical Plan

(Pre-65 Retiree Medical Plan)

Covering Eligible Pre-65 Retirees
and/or Eligible Dependents Under Age 65

PPO

High Deductible PPO 1

High Deductible PPO 2

Your Pre-65 Retiree Medical Plan Options

This is the SPD (the "Pre-65 Retiree Medical Plan SPD") for the NiSource Consolidated Flex Medical Plan, also referred to as the Pre-65 Retiree Medical Plan. In this Pre-65 Retiree Medical Plan SPD, the Pre-65 Retiree Medical Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") provides eligible Pre-65 Retirees and their eligible dependents, as well as eligible dependents of Post-65 Retirees who are covered under the Post-65 Retiree Medical Plan, with the following medical coverage options administered by Anthem BlueCross/BlueShield, each of which uses the Blue Cross/BlueShield Network:

- The Preferred Provider Organization (PPO);
- HDPPO 1 (HDPPO 1)
- HDPPO 2 (HDPPO 2)

Keep in mind that the Plan covers expenses based on a determination of the "Maximum Allowed Amount". Charges above the Maximum Allowed Amount are not paid by the Plan and are your responsibility. The Maximum Allowed Amount is determined based upon guidelines established by the Claims Administrator in its discretion from time to time. For more information about the determination of the Maximum Allowed Amount, please see the subsection below entitled *"Maximum Allowed Amount"*. If you have a question about the determination of the Maximum Allowed Amount, contact an Anthem customer service associate at the number on the back of your ID card.

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use Out-of-Network Providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

The HDPPO 1 and HDPPO 2 are both administered by Anthem. With these options, you may go in-network or out-of-network each time you seek care. The Plan pays more if you stay in the network. Office visits (for non-preventive care) and prescription drugs are subject to the same Deductible and Co-Insurance as other medical expenses. No medical or prescription drug benefits (except preventive and wellness care) are payable until you satisfy the annual Deductible. After you meet your Deductible, you will generally pay 20% of your expenses (assuming you use In-Network Providers) until you reach your out-of-pocket maximum. There are separate out-of-pocket maximums for in-network and out-of-network services. Once you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the calendar year.

If you enroll in either HDPPO 1 or HDPPO 2, you may be eligible to contribute to a Health Savings Account (HSA), although as a Pre-65 Retiree you may not contribute to an HSA through the Company. The money you contribute to an HSA can be used to reimburse you for eligible expenses that are not covered under the Plan.

To find a provider who participates in the network, log on to **anthem.com** or contact an Anthem customer service associate at the number on the back of your ID card.

Telemedicine Services

For PPO and HDPPO participants, Anthem makes available LiveHealth Online telemedicine services. With LiveHealth Online, you have access to a doctor 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. LiveHealth Online is available in all fifty states. Please visit the map at **livehealthonline.com** for more details.

LiveHealth Online is not meant to replace your primary care physician. Rather, it is a convenient option for care when your physician is not available. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more. LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

To start using LiveHealth Online, sign up at **livehealthonline.com** or download the app. To learn what mobile devices are supported and to get instructions, go to

livehealthonline.com and select **Frequently asked questions**. If you still have questions, you can email help@livehealthonline.com or call toll free at **1-888-548-3432**.

If you are at least 18 years of age, LiveHealth Online may also be used to see a therapist or psychologist in just a few days. To do this, use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you would like to see. Or, call LiveHealth Online at **1-888-548-3432** from 7 a.m. to 11 p.m. Eastern Time to schedule an appointment. **Please note:** Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it is important that you seek help immediately. Please call **1-800-273-8255** (National Suicide Prevention Lifeline) or **911** and ask for help. If your issue is an emergency, call **911** or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Personalized Health Guidance

Generally

If you enroll in the PPO option or one of the HDPPO options, you will have access to an Anthem Health Guide and, if needed, a primary nurse or other Personal Health Consultant) to answer your questions and provide personal health guidance—at no extra cost to you.

Your Anthem Health Guide

When you have questions about how your health care benefits work, what's covered or which medical facilities offer the best prices for tests or procedures, contact your Anthem Health Guide. Your Health Guide listens and works with you to get you answers fast. When you need extra support, your Anthem Health Guide can connect you to other resources, including your Personal Health Consultant

Your Personal Health Consultant

Each of us has different health needs. Sometimes it takes a team. Your Anthem Health Guides work closely with Personal Health Consultants. Personal Health Consultants are health care professionals like nurses, health coaches and social workers dedicated to giving personalized support to you and your family members.

Your Personal Health Consultant can answer your questions, help you get care and connect you to more resources. He or she can help you find other experts like dietitians and pharmacists, as well as help you stay on track with your doctors' treatment plans and medicines. Your Personal Health Consultant will work with you to:

- Find in-home support and resources when needed.
- Schedule appointments if you need surgery or a procedure.
- Manage a health issue and get the care you need.
- Recommend agencies in your community that might help you, local support groups and other online resources.
- Help understand what to expect if you spend time in a hospital and how to follow your doctor's plan of care.

To talk to an Anthem Health Guide or Personal Health Consultant call **1-800-228-2891**.

Prescription Drugs

If you are a PPO participant, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program, which coverage offers you access to a network of participating retail pharmacies for most of your short-term medications. You also have access to a mail order service for long-term or maintenance medications.

If you select the HDPPO 1 or HDPPO 2 coverage, you and your dependents are eligible for prescription drug coverage offered by the Anthem Prescription Drug Program. Prescription drug expenses are covered the same way as any other medical expenses, subject to the Deductible and Co-Insurance. These expenses are not subject to separate Co-Insurance or out-of-pocket maximum amounts. No prescription drug benefits are payable until you satisfy the annual Deductible.

To find a provider who participates in the PPO or HDPPO network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card to request assistance.

Mental Health/Substance Use Disorder Treatments

When you elect coverage under the PPO, HDPPO 1 or HDPPO 2 coverage options, you also receive coverage for mental health and substance use disorder treatments. A network of providers is available through Anthem BlueCross/BlueShield. To find a provider who participates in the network, log on to anthem.com or contact an Anthem customer service associate at the number on the back of your ID card.

You also have access to EAP/Work Life/Legal & Financial Services administered by Beacon Health Options. For additional details, see the section below entitled *"EAP/Work Life/Legal & Financial Services."*

Eligibility

For information regarding eligibility under the Pre-65 Retiree Medical Plan, please see the *"Eligibility under the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan"* subsection of the **Benefits Program Overview**.

Please Note: A Retiree who is rehired by an Employer other than NIPSCO, or who is rehired by NIPSCO other than as an Employee represented by a USW Union, shall lose eligibility for coverage as a Retiree under the Pre-65 Retiree Medical Plan (and shall not be eligible for such coverage upon his or her subsequent retirement), but may be eligible for coverage under the NiSource Consolidated Flex Medical Plan while an employee, subject to the terms and conditions for employee coverage under that Benefit Plan. *Please contact the Benefits Source at **1-888-640-3320** to speak to a service representative if you have any questions concerning your eligibility for retiree medical benefits in the event you are rehired as an employee.*

Enrollment

For information regarding enrollment in the Pre-65 Retiree Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan"*.

Contributions

The Employer and Retiree will contribute to the cost of the Plan in an amount determined on an annual basis. Please see the subsection of the **Benefits Program Overview** entitled *"Defined Dollar Subsidy for Retiree Medical Coverage"* for a discussion of a subsidy that may be available to reduce the cost of your coverage. For further questions, please contact the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Pre-65 Retiree 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 Pre-65 Retiree Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan"*.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select.

The UR Program offers the following services:

- Pre-admission authorization;
- Pre-Certification;

- Urgent Hospital Admission;
- Continued Stay Review;
- Other Required Pre-certifications; and
- Penalty for Non-Compliance.

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the Plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an urgent hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number will be provided to each participant. Hospital admission pre-certification does not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.
- **Pre-Certification Procedure:** When your physician recommends a non-urgent hospitalization, you or your physician must call the Pre-certification Provider. You must advise your physician of the Plan's pre-admission certification requirement and provide such physician with adequate information to obtain the pre-certification. You or your physician should secure pre-certification as soon as possible and before a covered person actually enters the hospital. It is your responsibility to see that the Pre-certification Provider is notified.
- **Urgent Hospital Admission:** In the case of an urgent hospitalization, the covered person's physician, the hospital, or a family member must telephone the Pre-certification Provider within 48 hours of admission or the first business day following weekend or holiday admissions. You must provide the Pre-certification Provider with the information required by the Pre-certification Provider.
- **Continued Stay Review:** The Pre-certification Provider may monitor all hospital stays through contact with the covered person's physician.
- **Other Required Pre-certifications:** You and your physician must notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (1) inpatient surgery, (2) a newborn child hospital stay beyond that of the mother; (3) plastic reconstructive surgery; and (4) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.
- **Penalty for Non-compliance:** If you fail to comply with the requirements as described above, the Plan may assess a $300 penalty.

Highlights of the PPO Option

Below is a summary of the Deductibles, Co-Pays, Co-Insurance amounts, and calendar year out-of-pocket maximums for the PPO Coverage Option.

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	$300 per covered member	$600 per covered member
• Covered Member + Spouse	$300 per covered person	$600 per covered person
• Covered Member + child(ren)	$300 per covered person, up to a total of $600	$600 per covered person, up to a total of $1,200
• Covered Member + Family (Spouse + children)	$300 per covered person, up to a total of $900	$600 per covered person, up to a total of $1,800
Office Visit Co-Pay/Co-insurance	$20	40% after Deductible
Out-of-Pocket Maximum	**You Pay**	**You Pay**
Calendar Year Out-of-Pocket Maximum (does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan) (includes Deductible and Co-Pay)		
• Covered Member	$1,300	$2,600
• Covered Member + Spouse	$2,600	$5,200
• Covered Member + Child(ren)	$2,600	$5,200
• Covered Member + Family	$3,900	$7,800

[†]Prescription drug expenses are not counted against the Calendar-Year Deductible.

FEATURE	PPO	
	In-Network (or out of area)	Out-of-Network
Other Plan Benefits	**Plan Pays**	
• Temporomandibular Joint Dysfunction and Related Medical Disorders	Benefits for surgical and non-surgical treatment	
• Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period (combined in-network and out-of-network)	
• Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year (combined in-network and out-of-network)	
• Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year (combined in-network and out-of-network)	
• Chiropractic/Spinal Manipulation Services	26 manipulations per calendar year (combined in-network and out-of-network)	
• Home Health Care	120 visits (combined in-network and out-of-network)	
• Hospice Care	Benefits for Hospice Care, with no limit on number of days of care, but subject to other Plan terms and conditions	
• Routine vision exams and hardware	First pair of lenses or frames following cataract surgery (otherwise, not covered) (combined in-network and out-of-network)	

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO coverage option. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	PPO	
	In-Network (or out of area)	**Out-of-Network**
TYPE OF SERVICE	**Plan Pays**	**Plan Pays**
Inpatient Services		
Room and Board and Ancillary Services	80% (after Deductible)	60% (after Deductible)
Surgery	80% (after Deductible)	60% (after Deductible)
Skilled Nursing Facility	80% (after Deductible)	60% (after Deductible)
Physician Services (Including General Nursing Care)	80% (after Deductible)	60% (after Deductible)
Pre-admission Testing	80% (after Deductible)	60% (after Deductible)
Outpatient Services		
Surgery	80% (after Deductible)	60% (after Deductible)
Dental/Oral Surgery	80% (after Deductible)	60% (after Deductible)
TMJ Appliances	80% (after Deductible)	80% (after in-network Deductible)
Second Surgical Opinions	100% (after $20 Co-Pay per office visit)	60% (after Deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	Out-of-Network
	Plan Pays	Plan Pays
Professional Services (Outpatient)	100%, (after $20 Co-Pay per office visit) (Co-Pay does not apply for allergy injections, serums, or testing)	60% (after Deductible)
Emergency Care Services		
Accident (True Emergencies)	100% (no Co-Pay)	100% (no Co-Pay)
Accident (True Emergencies) (Patient admitted to hospital)	100% (no Co-Pay)	100% (no Co-Pay)
Medical Emergency	80% (after Deductible)	80% (after Deductible)
Non-Medical Emergency	80% (after Deductible)	80% (after Deductible)
Urgent Care	100% (after $20 Co-Pay)	80% (after Deductible)
Ambulance	80% (after in-network Deductible)	80% (after in-network Deductible)
Rehab Services		
Inpatient Therapy	80% (after Deductible)	60% (after Deductible)
Outpatient Therapy	80% (after Deductible)	60% (after Deductible)
Diagnostic and Laboratory Services (Non-Routine)		
Inpatient	80% (after Deductible)	60% (after Deductible)
Outpatient	80% (after Deductible)	60% (after Deductible)
Allergy Testing	100% (after $20 Co-Pay per office visit only)	60% (after Deductible)

TYPE OF SERVICE	PPO	
	In-Network (or out of area)	Out-of-Network
	Plan Pays	Plan Pays
Maternity and Other Reproductive Services		
Pre-natal Office Visits	100% (after $20 Co-Pay for first office visit)	60% (after Deductible)
Hospital Maternity Care	80% (after Deductible)	60% (after Deductible)
Services to Diagnose Infertility[1]	80% (after Deductible)	60% (after Deductible)
Sterilization Services[2] (Precertification required for inpatient procedures)	80% (after Deductible)	60% (after Deductible)
Preventive Health Services		
Recommended Preventive Health Services	100% (no Co-Pay or Deductible)	60% (after Deductible)
Additional Preventive Health Services	80% (after Deductible)	60% (after Deductible)
Other Covered Services (including durable medical equipment and prosthetics/orthotics)	80% (after Deductible)	60% (after Deductible

[1] Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

[2] Sterilization procedures for women will be treated as a "Preventive Care" benefit. Reverse sterilization procedures are not covered.

How Deductibles Work in the PPO Option

For charges that are subject to the calendar year Deductible requirement under the PPO Coverage Option, a covered person generally must satisfy the "individual" covered person Deductible requirement (currently $300 for in-network and $600 for out-of-network) each calendar year before the Plan will pay any benefits for such charges. Charges incurred by a covered person may not be applied toward satisfaction of any other covered person's "individual" Deductible requirement.

However, once the "family" Deductible has been satisfied for a category of coverage (e.g., for In-Network Providers, $600 for covered member + Spouse or for covered member + child(ren), or $900 for covered member + family), additional covered persons within the family do not need to satisfy any Deductible requirement.

For example, if you choose the covered member + children category of coverage and you and one of your children each satisfy the $300 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 $600 of charges that are subject to the in-network Deductible requirement, one of your children who is a covered person must satisfy the $300 in-network Deductible requirement before the "family" Deductible requirement is met.

Please note that prescription drug expenses are not counted against the calendar year Deductible.

For the PPO Coverage Option only, charges that are incurred during the last three months of the calendar plan year and that are applied to the individual and family Deductible for such calendar plan year (that is, charges incurred before the Deductible is satisfied) apply also toward the Deductible requirement for the following calendar plan year.

Highlights of the HDPPO 1 and HDPPO 2 Options

Below is a summary of the Deductibles, Co-Pays, Co-Insurance amounts, and calendar year out-of-pocket maximums for the HDPPO 1 and HDPPO 2 Options.

Please Note: No medical or prescription drug benefits (except preventive care) are payable under the HDPPO 1 and HDPPO 2 options until you satisfy the annual Deductible.

Deductible, Calendar Year Out-of-Pocket Maximum, Maximum Benefits and Other Plan Benefits

	HDPPO 1		HDPPO 2	
FEATURE	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible				
Covered Member Only	$1,500	$3.000	$2,500	$5,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$3,000	$6,000	$5,000	$10,000

FEATURE	HDPPO 1		HDPPO 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Co-insurance	You pay 20% and the plan pays 80% (after Deductible)	You pay 40% and the plan pays 60% (after Deductible)	You pay 20% and the plan pays 80% (after Deductible)	You pay 40% and the plan pays 60% (after Deductible)
Calendar Year Out-of-Pocket Maximum (does not include premiums, balanced billed charges, penalties for non-compliance and expenses not covered under Plan)				
Covered Member Only	$3,000	$6,000	$5,000	$10,000
Covered Member + Spouse Covered Member + Child(ren) Covered Member + Family	$6,000	$12,000	$10,000 (but each covered person subject to no more than $8,550*)	$20,000 (but each covered person subject to no more than $15,000*)
Office Visit	You pay 20% and the Plan pays 80% (after Deductible)	You pay 40% and the Plan pays 60% (after Deductible)	You pay 20% and the Plan pays 80% (after Deductible)	You pay 40% and the Plan pays 60% (after Deductible)
Prescription Out-of-Pocket	Calculated as part of the calendar year out-of-pocket maximum		Calculated as part of the calendar year out-of-pocket maximum	

*Amounts are subject to change on at least an annual basis. Please contact the Benefits Source at 1-888-640-3320 for the current out-of-pocket expense limitation.

Services Provided

The following is a brief summary of the services that the Plan covers in the HDPPO 1 and HDPPO 2 Options. A covered expense to which Co-Insurance set forth below is applied shall not exceed the Maximum Allowed Amount.

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Inpatient Services				
Room and Board and Ancillary Services	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Surgery	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Skilled Nursing Facility	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Physician Services Including General Nursing Care	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Pre-admission Testing	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Outpatient Services				
Surgery	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Dental/Oral Surgery	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
TMJ Appliances	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Second Surgical Opinions	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Professional Services (outpatient)	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)

	HDPPO 1		HDPPO 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
TYPE OF SERVICE	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Emergency Care Services				
Accident	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)
Medical Emergency	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)
Non-Medical Emergency	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Urgent Care	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Ambulance	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)
Rehab Services				
Inpatient Therapy	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Outpatient Therapy	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Diagnostic and Laboratory Services				
Inpatient	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Outpatient	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)

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
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)*
Preventive Health Services				
Recommended Preventive Health Services	100% (no Co-Pay or Deductible)	100% (no Co-Pay or Deductible)	100% (no Co-Pay or Deductible)	100% (no Co-Pay or Deductible)
Additional Preventive Health Services	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)
Other Covered Services				
Durable medical equipment and prosthetics/orthotics	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)	80% (after Deductible)
Other covered services	80% (after Deductible)	60% (after Deductible)	80% (after Deductible)	60% (after Deductible)

*Coverage is provided for initial evaluation and for treatment and correction of the underlying condition only.

How Deductibles Work in the HDPPO 1 and HDPPO 2 Options

For charges that are subject to the calendar year Deductible requirement under the HDPPO 1 and HDPPO 2 Coverage Options, each calendar year the covered family as a unit must satisfy the specified Deductible requirement for a category of coverage before the Plan will pay any benefits for such charges.

Thus, for example, if you choose the covered member + family category of coverage and you incur $2,000 of charges that are subject to the in-network Deductible, but no other covered family member incurs any charges, you (or other covered family members) must still satisfy the remaining $1,000 of the in-network Deductible requirement before the Plan will pay any benefits. On the other hand, if you choose the covered member + family category of coverage and your Spouse incurs $3,500 of charges in a year that are subject to the in-network Deductible, no other family members will be subject to an in-network Deductible requirement for that year.

The Individual Out-of-Pocket Maximum Limit in the HDPPO 2 Option

In the HDPPO 2 Coverage Option, for categories of coverage other than "covered member only," there is an individual out-of-pocket maximum limit. This means that regardless of the overall out-of-pocket maximum limit for the category of coverage, no covered person will pay more than the individual out-of-pocket maximum for expenses that are subject to that limit. For services received from In-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is equal to $8,550. For services received from Out-of-Network Providers, the individual out-of-pocket maximum as of January 1, 2021 is $15,000.

Maximum Allowed Amount

General

This section describes how Anthem, as Claims Administrator for the Plan, determines the amount of reimbursement for services, treatments or supplies covered by the Plan ("Covered Services"). However, this section does not address Covered Services under the Plan for which claims are not administered by Anthem.

Reimbursement for services, treatments or supplies rendered or furnished by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator will allow for services, treatments and supplies:

- to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's

application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for the Plan or in a closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website, anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for the Plan will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for the Plan, but contracted for other benefit plans with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Notwithstanding the foregoing, when determining the Maximum Allowable Amount for Out-of-Network emergency services, the Claims Administrator will provide benefits for such services in an amount at least equal to the greatest of the methods required under the Affordable Care Act and the regulations thereunder (adjusted for in-network cost sharing).

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call an Anthem customer service associate at the number on the back of your ID card for help in finding an In-Network Provider or visit the Claims Administrator's website, anthem.com.

An Anthem customer service associate is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although an Anthem customer service associate can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs Obtained through the HDPPO

For prescription drugs obtained under an HDPPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the PBM for that Option.

Participant Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Highlights of the PPO Option, Highlights of the HDPPO 1 and HDPPO 2 Options, and Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options sections in this Pre-65 Retiree Medical Plan SPD for your cost share responsibilities and limitations in the Plan, or call an Anthem customer service associate at the number on the back of your ID card to learn how the Plan's benefits or cost share amounts may vary by the type of Provider you use.

Special Cost-Sharing Provisions during Public Health Emergency

During any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)), beginning on or after March 18, 2020, the Medical Plan will provide coverage of the following items and services without any cost sharing (including Deductibles, Co-Payments, and Co-Insurance) requirements or prior authorization or other medical management requirements, to the extent (i) required by applicable law, (ii) medically appropriate for you, as determined by your attending healthcare provider in accordance with accepted standards of current medical practice, and (iii) ordered by your attending healthcare provider:

(a) An in vitro diagnostic test as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that—

  (1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);

  (2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

  (3) is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or

  (4) other tests that the Secretary of HHS determines appropriate in guidance.

(b) Items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (a), but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Reimbursement of Out-of-Network Providers furnishing any of the foregoing items or services shall not exceed an amount that equals the cash price for such service as listed by the Provider on a public internet website.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Non Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Pre-65 Retiree Medical Plan SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain prescription drug purchases under this Plan and which positively impact the cost effectiveness of

Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Co-payment, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact an Anthem customer service associate at the number on the back of your ID card for Authorized Services information or to request authorization.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependents) for Medically Necessary eligible expenses up to the Maximum Allowed Amount.

For expenses not covered under the PPO and HDPPO options, see the section below entitled *"Medical Expenses Not Covered."*

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Pre-65 Retiree Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 28.

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable law. Notwithstanding the foregoing, the Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan and the Plan may establish varying reimbursement rates based on quality or performance measures.

The covered expenses under the Plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room;
  - A private room (the Plan limits benefits to the hospital's prevailing semi-private room rate); or
  - An intensive care unit.

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges;
  - X-rays;
  - Laboratory work;
  - Surgical dressing; and
  - Prescribed medications (Outpatient prescription drug services are covered under the prescription drug program. See the sections of this Handbook relating to Prescription Drugs for details).

- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care; and
  - Ancillary services (such as drugs, surgical dressings, or supplies).
- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room;
  - A private room; or
  - An intensive care unit.
- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis:

- Hospital facility services and ancillary charges for services performed on an outpatient basis;
- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery;
  - Surgeon's fees when related to the surgical procedure; and
  - Surgery for morbid obesity.
- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 12 months of injury), to extract completely bony impacted teeth, including completely impacted wisdom teeth, or (for the PPO option only) in connection with a gingivectomy. The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety.
- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate; and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).
- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery.

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the Co-Pay or Deductible requirement, as applicable, before the Plan pays benefits.
- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Hearing exams and hearing aids. The Plan limits benefits to one hearing exam and one hearing aid per ear during a two calendar-year period; and
- Diabetes management services, including:

- Educational services;
- Eye exams; and
- Blood glucose testing machines (diabetic supplies and other diagnostics are covered under the prescription drug coverage).

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency; or
  - A non-medical emergency.
- Urgent care;
- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services.

- The following rehabilitation services provided on an inpatient or outpatient basis (unless otherwise noted):
  - Physical Medicine/Rehabilitation (PMR) (inpatient only, limited to 60 days per person per year; outpatient PMR is considered physical therapy and is subject to the limits outlined below for outpatient physical therapy). The Plan may extend these limits based upon medical necessity;
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion; and
  - Renal dialysis treatments.
- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or injury or surgery on account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician. Benefits for physical therapy and occupational therapy are limited to a combined 26 visits per person per year. Benefits for speech therapy are limited to 26 visits per person per year. Additional visits for physical therapy, occupational therapy, and speech therapy may be authorized based upon medical necessity.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity to 26 manipulations per person per year;

- Physiotherapy, provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your Spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services
- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests; and
  - Laboratory tests and exams.

Preventive Health Services

Generally

The Plan pays benefits for certain preventive health services.

Preventive health services include outpatient services and office services. Screenings and other services are covered as preventive health services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive health services for that condition, but instead benefits will be considered as diagnostic services.

Without limiting the generality of the foregoing, if performed as a preventive care service or screening, the Plan pays benefits for one in-network colonoscopy per covered person per calendar year, and one in-network mammography per covered person per calendar year with no Deductible, Co-Insurance or Co-Payment requirement, notwithstanding that any treatment incidental or ancillary to such service or screening (such as the removal of polyps during a diagnostic colonoscopy) is also performed during such service or screening.

Preventive health services covered under the Plan may constitute either recommended preventive health services or additional preventive health services. Additional preventive health services are certain preventive health services covered under the Plan that do not constitute recommended health services. Please contact an Anthem customer service associate using the number on the back of your ID card for any questions concerning what constitutes a recommended preventive health service or an additional preventive health service. Additional preventive health services furnished by In-Network Providers are covered by the Plan with no Deductible, Co-Payments or Co-Insurance. Additional preventive health services furnished by Out-of-Network Providers are subject to Deductibles and Co-Insurance under the PPO option, but are covered by the Plan with no Deductible, Co-Payments or Co-Insurance under the HDPPO options.

Recommended preventive health services shall meet requirements as determined by Federal law and, if applicable, state law. Recommended preventive health services are covered by this Plan with no Deductible, Co-Payments or Co-Insurance under the HDPPO options and when furnished by an In-Network Provider under the PPO option. Recommended preventive health services furnished by an Out-of-Network Provider under the PPO option are subject to Deductibles and Co-Insurance.

To the extent required by federal regulation, if there is no In-Network Provider who can provide a recommended preventive health service, the Plan will cover the service, with no Deductible, Co-Payment or Co-Insurance, when performed by an Out-of-Network Provider.

Categories of Recommended Preventive Health Services

Recommended preventive health services fall under four broad categories, described below, that are specified in federal

regulations regarding coverage of preventive health services:

- Evidenced-based items or services that have in effect a rating of "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009 (which are not considered to be current). These items or services may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific USPSTF recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  — Abdominal aortic aneurysm screening: men;
  — Alcohol misuse: screening and counseling
  — Blood pressure screening in adults;
  — BRCA risk assessment and genetic counseling/testing;
  — Breast cancer preventive medications;
  — Breast cancer screening;
  — Cervical cancer screening;
  — Colorectal cancer screening;
  — Diabetes screening;
  — Lung cancer screening;
  — Obesity screening and counseling: adults and children;
  — Osteoporosis screening: women;

  See the following website for additional items and services that may be covered and for additional details: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) with respect to the individual involved (for this purpose, a recommendation from the ACIP is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

  The immunizations for adults may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical condition and population for which such immunizations are appropriate:

  — Diphtheria;
  — Hepatitis A;
  — Hepatitis B;
  — Herpes Zoster;
  — Human Papillomavirus;
  — Influenza (flu shot)
  — Measles
  — Meningococcal;
  — Mumps;
  — Pertussis;
  — Pneumococcal;
  — Rubella;
  — Tetanus;
  — Varicella (chickenpox).

  The immunizations for children may include the following, subject to the limitations and conditions set forth in the specific recommendations, including limitations and conditions relating to variations in age, gender, medical history or condition, risk factors or population for which such immunizations are appropriate:

  — Diphtheria, Tetanus, Pertussis;
  — Haemophilus influenza type b;
  — Hepatitis A;

- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza;
- Measles;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella (chickenpox).

See the following website for additional information: https://www.cdc.gov/vaccines/acip/recs/index.html

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), subject to the limitations and conditions with respect to such services, including timing and frequency, that are set forth in the specific HRSA guidelines.

  In addition to preventive care and screening already noted above, such preventive care and screenings may include the following, subject to the limitations and conditions with respect to such services that are set forth in the specific recommendations, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, gender or medical history or condition, of those individuals for which such items or services may be appropriate:

  - Alcohol and drug use assessments;
  - Autism screening;
  - Behavioral assessments;
  - Blood pressure screening;
  - Cervical dysplasia screening for sexually active females;
  - Developmental screening for children under age 3;
  - Dyslipidemia screening for children at higher risk of lipid disorders;
  - Fluoride chemoprevention supplements;
  - Height, weight and body mass index measurements;
  - Hematocrit or hemoglobin screening;
  - Lead screening;
  - Medical history for all children through development ages;
  - Oral health risk assessments for children age 0 to 10 years;
  - Sexually transmitted infection prevention counseling and screening for adolescents at higher risk;
  - Tuberculin testing for children at higher risk of tuberculosis

  See the following website for additional information: https://www.healthcare.gov/preventive-care-children/.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, to the extent not included in certain recommendations of the USPSTF. In addition to preventive care and screening already noted above, such care and screenings may include the following, subject to the terms, limitations and conditions set forth in the specific HRSA guidelines, including limitations and conditions relating to the timing and frequency of such services and the designation, by age, medical history or condition, or risk factors of those individuals for which such items or services may be appropriate:

  - Well-woman visits;
  - Counseling and screening for human immune-deficiency virus;
  - Human papillomavirus testing;
  - Contraceptive methods and counseling (incl. devices such as diaphragms, intra-uterine devices (IUDs) and implants);
  - Screening for gestational diabetes;
  - Screening and counseling for interpersonal and domestic violence;
  - Counseling for sexually transmitted infections;

- Breastfeeding support, supplies, and counseling (benefits for breast pumps are limited to one per Plan Year).

See the following website for additional information: http://www.hrsa.gov/womensguidelines/.

Limitations With Respect To Recommended Preventive Health Services

The services described in the recommendations or guidelines above will not constitute recommended preventive health services earlier than Plan Year that begins on or after the date that is one year after the recommendations or guidelines are issued; provided, however, that recommended preventive health services shall include any "qualifying coronavirus preventive service," as defined in applicable federal regulations, on the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service.

Please note: Regardless of whether such services continue to be listed above, recommended preventive health services will remain Covered Services under the Plan only until the end of the Plan Year following the date the related recommendation or guideline is no longer described in the federal regulations regarding coverage of preventive health services. Provided, however, that to the extent a service covered on the first day of a Plan Year is, during the Plan Year, downgraded to a "D" rating, or any item or service associated with any recommendation or guideline described in the federal regulations regarding coverage of preventive health services is subject to a safety recall or is otherwise determined by a federal agency authorized to regulate the item or service to pose a significant safety concern, such service will cease to be a covered service as of the date of the rating downgrade or agency determination.

Please also note: The frequency, method, treatment and setting of recommended preventive health services are subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion. Please contact an Anthem customer service associate using the number on the back of your ID card for information concerning any limitations upon recommended preventive health services arising out of the use of such techniques.

If a recommended preventive health service is billed separately (or is not tracked as individual encounter data separately) from an office visit, then the Plan may impose a Co-Payment and/or Deductible for the office visit. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive health service, then the Plan will not impose a Co-Payment, Co-Insurance and/or Deductible for the office visit, unless you have chosen the PPO option and the office visit involves an Out-of-Network Provider. If a recommended preventive health service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive health service, then the Plan may impose a Co-Payment, Co-Insurance and/or Deductible for the office visit.

Additional Information

You may contact an Anthem customer service associate using the number on the back of your ID card for additional information about these recommended preventive health services (or you may view the following federal government websites:

https://www.healthcare.gov/preventive-care-benefits;

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/;

https://www.cdc.gov/vaccines/acip/recs/index.html; and

http://www.hrsa.gov/womensguidelines/).

Gender Reassignment Surgery

Generally

Gender reassignment surgery is one treatment option for extreme cases of gender

dysphoria. It is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual.

Plan Benefits for Specific Surgeries

The Plan pays benefits for gender reassignment surgery consisting of any combination of the following, if the Plan Administrator determines in its sole and absolute discretion that each such surgery is Medical Necessary: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses.

See the *"Definitions"* subsection of the **Benefits Program Overview** for what constitutes a Medically Necessary service or supply. For a surgery to be considered Medically Necessary, all criteria established by the Plan Administrator for such surgery must be satisfied. For information concerning the criteria to be satisfied to establish medical necessity, please contact an Anthem customer service associate using the number on the back of your ID card.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to any gender reassignment surgery. Be sure to contact Anthem before you proceed with any gender reassignment surgery or related procedure.

Cosmetic Procedures or Services Not Covered

Cosmetic procedures or services in connection with gender reassignment surgery are not covered under the Plan. Without limiting the generality of the foregoing, the following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow Lift
- Calf Implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reduction thyroid chondroplasty
- Rhinoplasty
- Voice modification surgery
- Voice therapy

These cosmetic surgeries are not covered under the Plan.

Maternity and Infertility

The Plan pays benefits for the following pre-natal and maternity services for you, your Spouse, and your female children who are covered under the Plan:

- Pre-natal office visits, including one routine ultrasound;
- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one Deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);
  - Inpatient pediatrician visits; and
  - Birthing center expenses.

The Plan pays maternity benefits for services provided to the mother (if covered under the

Plan) as well as certain services provided to the newborn infant while the mother is hospitalized after childbirth (even if you initially have Retiree-only coverage). However, if the newborn requires treatment for an illness or injury or remains hospitalized after the mother is discharged from the hospital after giving birth, the Plan pays benefits for that care only if you add the newborn to coverage, provided the newborn is eligible for coverage under the Plan. (The newborn child of your female child is not eligible for coverage under the Plan.) To add an eligible newborn child to your coverage, you must call the Benefits Source at **1-888-640-3320**, or log on to the Benefits Source website, mysourceforhr.com, and add the newborn child within 31 days of the actual birth. Provided the newborn child is eligible for coverage and you timely enroll the child, coverage for the newborn takes effect as of the date of birth. Please see the "*Enrollment*" and the "*Changing and Continuing Your Elections*" section of the **Benefits Program Overview** for further details.

> **Please Note:**
>
> If you do not enroll an eligible newborn child in the Plan within 31 days of the child's birth, as such time period may be extended by the Outbreak Period, 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 also pays benefits for services performed to diagnose infertility. However, the Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);
- Blood and blood components;
- Durable medical equipment and supplies, including:
  - The rental of wheelchairs and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);
  - Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator.

  The Plan pays benefits for the rental of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).
- Elective vasectomies and tubal ligations for the participant and his or her Spouse (**Please note** that sterilization procedures for women will be covered as Preventive Care benefits);
- Extended care facility (convalescent care), as approved through the Claims Administrator;
- Home health care services. The Plan pays benefits as long as home health care is medically necessary, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services (RN or LPN);
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;
  - Medically necessary services, supplies, and medications.

- Hospice care services. For the PPO coverage option, care must be provided through an accredited hospice care program and the hospice care program must be approved by the Claims Administrator and be licensed, certified or registered, if the state in which it is located requires the same. For the HDPPO coverage options, the hospice care program must be licensed. Covered services include:

  — Coordinated home care;

  — Medical supplies and dressings;

  — Medications;

  — Nursing services (skilled and non-skilled);

  — Occupational therapy;

  — Pain management services;

  — Physical therapy; and

  — Physician visits.

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less.

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them. Charges incurred during periods of remission are not covered.

- Human organ and tissue transplant services. The Plan pays benefits for any medically necessary human organ and tissue transplant, as determined by the Plan Administrator, including necessary acquisition costs and preparatory myeloblative therapy, and for all covered services that are (i) Medically Necessary, as determined by the Plan Administrator, and (ii) directly related to the disease that has necessitated the covered transplant procedure or that arise as a result of the procedure, including any diagnostic evaluation for the purpose of determining the appropriateness of the procedure for a covered person.

For cornea and kidney transplants, the benefits or requirements described below do not apply. These services are paid as inpatient services, outpatient services or physician office services, depending where the service is performed.

The Plan pays benefits only for facility and provider expenses that are described as covered expenses elsewhere in this Handbook.

Before the Plan pays benefits, Anthem, as Claims Administrator, must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. Be sure to contact Anthem before you proceed with any treatment related to a transplant.

You should contact Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Anthem Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Anthem will then assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any Plan provisions, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you. If you choose an out-of-network facility or provider, the Plan will pay covered expenses based upon a determination of the Maximum Allowed Amount and you will be responsible for any amount not paid by the Plan.

Without limiting the generality of the foregoing, the Plan pays benefits for the following medically necessary services related to a human organ or tissue transplant:

— Physician's charges related to surgery, including charges for a surgical physician's assistant (if medically necessary), and related anesthesia.

— Inpatient covered hospital services related to the transplant procedure.

— Storage and transportation costs related to the donated organ or tissue (including the donor's medical expenses incurred as the result of a transplant provided the recipient is covered under

the Plan, the expense is charged to the covered person, and no other source is available to pay the actual donor's medical expenses).

- Storage of the patient's own blood in advance of an approved transplant surgical procedure.

If a participating (in-network) transplant facility performs transplant-related services, the Plan pays benefits for medically necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the facility where your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the covered person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Benefits for lodging are limited to $75.00 per day. There is a $20,000 combined maximum for travel and lodging. The covered person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator when claims are filed.

Contact the Plan Administrator for detailed information.

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;
- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas).
- Vision exams and first pair of eyeglasses or contact lenses following cataract surgery;
- Oxygen and its administration, including the rental of equipment for its administration;
- Private duty nursing services provided by an R.N. or L.P.N. who is not a relative.
- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue.

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there is significant wear on the appliance).

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

Medical Expenses Not Covered

Expenses Not Covered Under Pre-65 Retiree Medical Plan

The medical expenses **not** covered under the Pre-65 Retiree Medical Plan include, but may not be limited to, the following:

- Services or supplies relating to the treatment of any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service that are provided or available from the Veterans' Administration or military facilities as required by law;
- Services for custodial care;

- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered;
- Charges for treatment received before coverage under this Option began or after it is terminated;
- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the judgment of the Claims Administrator, Experimental or Investigational for the diagnosis for which the covered person is being treated. Notwithstanding any other provision of the Plan, if a covered person is a "qualified individual," as defined in Section 2709 of the Affordable Care Act, the Plan will not (i) deny such person's participation in an "approved clinical trial," as also defined in Section 2709, (ii) deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in such trial, or (iii) discriminate against such person on the basis of his or her participation in the trial. If an In-Network Provider is participating in the approved clinical trial, the Plan may require participation in the trial through such In-Network Provider, if the Provider will accept the covered person as a participant in the trial;
- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of a Sickness or Injury, as determined by the Claims Administrator;
- Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for covered persons with impaired circulation to the lower extremities;
- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the covered person had applied for such benefits. Services that can be provided through a government program for which the covered person as a member of the community is eligible for participation. Such programs include, but are not limited to, school speech and reading programs;
- Services paid under Medicare or which would have been paid if the covered person had applied for Medicare and claimed Medicare benefits, except as specified elsewhere in the Plan or as otherwise prohibited by Federal law. Except as otherwise required by applicable Federal law, with respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the covered person has enrolled in Medicare Part B;
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;
- Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;
- Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or Sickness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;
- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific Sickness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary;
- Services for Hospital confinement primarily for diagnostic studies;
- Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect;
- Donor search/compatibility fee (except as otherwise indicated in the Plan);
- Hearing aids, hearing devices or examinations for prescribing or fitting them;
- Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;
- In-vitro fertilization and artificial insemination;
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided as a Covered Service under the Plan;
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;
- Services of a Christian Science Practitioner;
- Certain services and supplies for smoking cessation programs and treatment of nicotine addiction;
- Services provided in a halfway house for substance abuse rehabilitation;
- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a covered person for which, in the absence of any health benefits coverage, no charge would be made; services provided to the covered person by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the covered person is not required to pay for them or they are provided to the covered person for free;
- Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;
- Elective abortions;
- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

- Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;
- Care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Examinations relating to research screenings;
- Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;
- Stand-by charges of a Physician;
- Routine care is not covered, except for preventive health services expressly provided for by the Plan;
- Biofeedback;
- Services or supplies provided by a member of a covered person's family or household;
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;
- Fees or charges made by an individual, agency or facility operating beyond the scope of its license;
- Services and supplies for which a covered person has no legal obligation to pay, or for which no charge has been made or would be made if the covered person had no health insurance coverage;
- Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results; specific medical reports including those not directly related to the treatment of the covered person, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
- Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- Personal comfort items such as those that are furnished primarily for a covered person's personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies;
- Reversal of vasectomy or tubal ligation;
- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne;
- Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy unless Medically Necessary;
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, for the first pair of eyeglasses or contact lenses prescribed following cataract surgery, or for soft contact lenses due to a medical condition, i.e. diabetes;
- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or

astigmatism or any other correction of vision due to a refractive problem; and

- Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Please contact the Claims Administrator with questions regarding those medical expenses not covered.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

How Your Prescription Drug Coverage Works in the PPO

When you participate in the PPO coverage option under the Plan, you are also provided with prescription drug coverage through the Anthem Prescription Drug Program. HMOs will provide separate prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.
- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.
- Non-formulary – Drugs that are not on the formulary list, but generally have a formulary alternative. You may choose non-formulary drugs, but you will pay more than a generic or formulary drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The PPO coverage option utilizes a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the PPO coverage option, regardless of whether you use a retail pharmacy or the mail order service, if a generic substitute for a brand-name drug is prescribed or if your Provider has not indicated that a brand-name drug is Medically Necessary, and if you request that the brand-name drug be dispensed, you will be responsible for payment of the applicable Co-Payment or Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

You can fill your prescription at any participating pharmacy.

Retail

If you fill your prescription at a participating retail pharmacy, you need to meet a Co-Pay requirement. If your share of the drug's cost is less than the "minimum Co-Pay," you pay the minimum Co-Pay amount. If your share of the drug's cost is greater than the "maximum Co-Pay," you pay up to the maximum Co-Pay amount. See the "*Highlights of Your Prescription Drug Coverage in the PPO Option*" section of this Pre-65 Retiree Medical Plan SPD for further details on plan benefits.

The Plan provides no coverage for prescriptions filled through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the PBM.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the

Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program you pay 20% of the cost of a three-month supply of the drug with applicable minimum and maximum of three times retail Co-Pays.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Anthem's mail order service. With the mail order service, you must submit your prescription and applicable Co-Pay amount through the mail. The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

- Complete the Mail Service Pharmacy Order Form. A new order form and envelope will be sent to you with each delivery. ***Please note:*** *The registration/profile process may also be completed over the phone or online.*
- Attach the prescription and a check in the amount of the applicable Co-Pay. Make your check payable to ***Anthem*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.
- Mail the Mail Service Pharmacy Order Form and your check to the Anthem mailing address included on the Form.
- Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:
  - One for an immediate supply (you can then take this to your local participating pharmacy)
  - A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website, **anthem.com**.

See the "*Highlights of your Prescriptions Drug Coverage in the PPO Option*" section for further details on plan benefits.

Highlights of Your Prescription Drug Coverage in the PPO Option

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO coverage option.

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	$10 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	$30 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	$60 Co-Pay	100% after Co-Pay	20% for the cost of drug subject to minimum Co-Pay of $60 and maximum Co-Pay of $180
Out-of-Pocket Maximum					
The maximum amount you have to pay out of your pocket each year			$1,500 per person per year and $9,300 per family per calendar year		
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		

*You either pay a percentage of the drug's cost (Co-Insurance), or a set Co-Payment amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum Co-Payment," you pay the minimum Co-Payment amount. If your percentage of the cost results in an amount that is **greater than** the "maximum Co-Payment," you pay up to the maximum Co-Payment amount. For the PPO Coverage Option, if a generic substitute for a brand-name drug is prescribed or if your Provider has not indicated that a brand-name drug is Medically Necessary, and if you request that the brand-name drug be dispensed instead, 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 or Co-Insurance.

How Your Prescription Drug Coverage Works in the High Deductible Options

Regardless which High Deductible Option you participate in, you are covered under the Anthem Prescription Drug Program for your prescription drug coverage.

Prescription drug expenses are covered the same way as any other medical expense, subject to the Deductible and Co-Insurance. These expenses are not subject to separate Co-Insurance or out-of-pocket maximum amounts. The drug plan is an open formulary, so there is no designation in terms of generic, brand, etc. Therefore, you will pay the discounted cost of the drug.

The Plan and the PBM have an agreement whereby the PBM periodically makes refunds to the Plan based upon the Plan's actual utilization pattern of specific drugs. The Plan retains these amounts.

The High Deductible Options utilize a Quantity Limit Management program for certain prescription drugs. This program limits the amount of medicine that's covered by your plan for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you. Taking too much medicine or using it too often is dangerous and costly. That's why this program may limit how much of your medicine you can get each month. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. Since the drug list is updated on a regular basis, you can always find the most current details and covered quantity limits when you log in at **anthem.com**.

The High Deductible Options utilize a step care therapy program for certain classes of prescription drugs. For a list of the drugs included in this program, please contact Anthem at the number on the back of your ID card. This program requires the utilization of an effective first-line medication before a more expensive alternative may be covered under the Plan. Therefore, medications that meet established guidelines and/or have a generic alternative must be used as the first-line medication before more expensive medications are authorized, unless your doctor informs Anthem otherwise.

The High Deductible Options utilize a clinical prior authorization (CPA) program. CPA simply means you must get approval from Anthem before certain prescription drugs will be covered under the Plan. The CPA program reviews the use of certain very costly drugs, certain drugs that could be abused by the patient, and drugs that might not be the best choice for the patient's health problem. To see if the CPA program applies to a particular drug prescribed for you, contact Anthem toll-free at **1-800-228-2891**.

Also, for the High Deductible Options, regardless of whether you use a retail pharmacy or the mail order service, if a brand-name drug has a generic substitute (that is, a drug with the same active ingredients as the brand-name drug), and if you or your Provider request that the brand-name drug be dispensed, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

Retail Service

If you fill your prescription at a retail pharmacy and have not satisfied your Deductible, you will pay the discounted cost of the drug. If you have satisfied your Deductible, you will pay the applicable Co-Insurance amount, either 20% or 40%, dependent upon whether the pharmacy offers Anthem discounts.

To find out if your pharmacy is in the network, contact Anthem at **1-800-228-2891** to speak with a customer service representative. You may also log on to the Anthem website, **anthem.com**.

Ninety-Day Supply At Retail Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Ninety-Day Supply At Retail Program. The prescription must be filled at a network pharmacy participating in the Ninety-Day Supply At Retail Program. With this program

you pay 20% of the cost of a three-month supply of the drug after you satisfy your Deductible.

Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through the mail order service.

With the mail order service, you must submit an original prescription from your doctor and:

- Complete the Mail Order Pharmacy Form. *A new order form envelope will be sent to you with each delivery.*
- Attach the prescription and a check in the amount of the applicable discounted cost of the drug or Co-Insurance.
- Mail the Mail Order Pharmacy Form and your check to the address on the Form.

If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy and
- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received. To request a form or if you have questions, you may go to the Anthem website **anthem.com** or contact mail order customer service at **1-800-228-2891** to ask for assistance.

See the *"Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options"* section for further details on Plan benefits.

Highlights of Your Prescription Drug Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your prescription drug coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

	RETAIL PHARMACY		MAIL ORDER		NINETY-DAY SUPPLY AT RETAIL	
	You Pay*	**Plan Pays**	**You Pay***	**Plan Pays**	**You Pay***	**Plan Pays**
In-Network	20% (after Deductible is met)	80% for providers offering Anthem discounts	20% (after Deductible is met)	80% for providers offering Anthem discounts	20% (after Deductible is met)	80% for providers offering Anthem discounts
Out-of-Network	40% (after Deductible is met)	60% for providers not offering Anthem discounts	40% (after Deductible is met)	60% for providers not offering Anthem discounts	NA**	NA**
	Retail Pharmacy		**Mail Order**		**Ninety-Day Supply at Retail**	
Day Supply Limit	30-day supply		90-day supply		90-day supply	
Use For:	Short-term medications or immediate prescription drug needs		Long-term, maintenance, and injectable medications		Long-term, maintenance, and injectable medications	

*Please Note: No prescription drug benefits are payable under the HDPPO 1 or HDPPO 2 Options until you satisfy the annual Deductible. Also, if a brand-name drug has a generic substitute and you or your Provider request that a brand-name drug be dispensed instead of its generic substitute, you will be responsible for the applicable Co-Insurance plus the difference in cost between the brand-name drug and the generic substitute.

**Ninety-Day Supply at Retail is not available for out-of-network pharmacies.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following supplies and Federal legend drugs (except those listed as not covered):

- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride vitamins to age 19;
- Vitamins, if prescribed;
- Immunosuppressants;
- Injectables, other than insulin;
- Prescription contraceptive drugs (non-injectable monthly, non-injectable 90-day supply only, injectable monthly and injectable 90-day supply only) and contraceptive devices such as diaphragms, intrauterine devices (IUDs) and implants;

Please Note: Prescription contraceptive drugs and contraceptive devices for women will be covered as a recommended preventive health service with no Co-Pays or Deductibles; provided, however, if you request that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, you will be required to pay the regular Co-Pay, in the case of the PPO Option, or the applicable Deductible, in the case of an HDPPO Option.

- Retin-A, up to age 25;
- Diabetic diagnostics;
- Certain smoking cessation products;
- Compound medication of which at least one ingredient is a legend drug; and
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.

Prescription Drug Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but are not limited to the following:

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Drugs prescribed for cosmetic reasons;
- Drugs used for the treatment of infertility or relating to conception;
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;
- Hair treatments;
- Anti-wrinkle treatment;
- Blood glucose testing machines;
- Vaccines, serums and allergens;
- Nutritional dietary supplements;
- Over-the-counter medications; and
- Any item that is not legally procured, including without limitation any drug that may not legally be imported from another country.

Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered under the Plan.

How Your Mental Health/ Substance Use Disorder Coverage Works in the PPO Option

If you participate in the PPO coverage option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in the PPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. Mental Health and Substance Use Disorder Coverage is administered by Anthem. Employee Assistance Program (EAP)/Work Life/Legal & Financial Services benefits are administered by Beacon Health Options. Please refer to the "*Highlights of Your Mental Health and Substance Use Disorder Coverage in the PPO Plan Option*" and the *"EAP/Work Life/Legal & Financial Services"* sections of this Pre-65 Retiree Medical Plan SPD for further details of the Plan coverage.

How Your Mental Health/ Substance Use Disorder Coverage Works in the High Deductible Options

If you participate in the High Deductible PPO 1 or High Deductible PPO 2 Option, you are also provided with Mental Health and Substance Use Disorder Coverage. Regardless of whether you participate in an HDPPO coverage option, you are automatically enrolled in Employee Assistance Program (EAP)/Work Life/Legal & Financial Services coverage. The mental health and substance use disorder benefits are administered through Anthem. The EAP/Work Life/Legal & Financial Services benefits are administered through Beacon Health Options. Please refer to the *"Highlights of Your Mental Health and Substance Use Disorder Coverage in the High Deductible PPO 1 and High Deductible PPO 2 Options"* and the *"EAP/Work Life/Legal & Financial Services"* sections of this Pre-65 Retiree Medical SPD for further details of the Plan coverage.

Highlights of the Mental Health and Substance Use Disorder Coverage in the PPO Option

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the PPO Option.

Mental Health and Substance Use Disorder	In-Network Plan Pays	Out-Of-Network Plan Pays*
• Mental Health Inpatient	85% (after Deductible)	65% (after Deductible)
• Mental Health Outpatient	100% (after $15 Co-Pay)	65% (after Deductible)
• Substance Use Disorder (Detox Inpatient)	85% (after Deductible)	65% (after Deductible)
• Substance Use Disorder (Detox Outpatient)	100% (after $15 Co-Pay)	65% (after Deductible)
• Substance Use Disorder (Rehab Inpatient)	85% (after Deductible)	65% (after Deductible)
• Substance Use Disorder (Rehab Outpatient)	100% (after $15 Co-Pay)	65% (after Deductible)

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Highlights of Your Mental Health and Substance Use Disorder Coverage in the HDPPO 1 and HDPPO 2 Options

Here is a brief summary of your Mental Health and Substance Use Disorder coverage if you select medical coverage under the HDPPO 1 or HDPPO 2 Options.

Please Note: No Mental Health or Substance Use Disorder benefits in the HDPPO 1 or HDPPO 2 Options are payable until you satisfy the annual Deductible.

Mental Health and Substance Abuse	In-Network Plan Pays (after Deductible)	Out-of-Network* Plan Pays (after Deductible)
• Mental Health Inpatient	80%	60%
• Mental Health Outpatient	80%	60%
• Alternative Levels of Care	80%	60%
• Substance Abuse (Rehab Inpatient)	80%	60%
• Substance Abuse (Rehab Outpatient)	80%	60%

*For Out-of-Network Providers, the Plan pays benefits for eligible expenses based on a determination of the Maximum Allowed Amount. The Plan does not pay benefits for any expense that is above the Maximum Allowed Amount. As a result you are responsible for any charges that exceed the Maximum Allowed Amount.

Mental Health and Substance Use Disorder Treatment Expenses Covered Under the PPO and High Deductible Options

The PPO and HDPPO medical plan options limit benefits for inpatient and outpatient mental health and substance use disorder treatments. Please contact the Claims Administrator for details regarding the limits that apply.

Please refer to the *"EAP/Work Life/Legal & Financial Services"* section below for a description of employee assistance benefits provided under the Plan.

The covered mental health and substance use disorder expenses include, but may not be limited to the following:

- Inpatient facility and physician services provided for mental health and substance use disorders, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance use disorder, including:
  - Detox and rehab substance use disorder services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance use disorder treatment facility;
  - Services provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program.
- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance use disorder illness and its treatment;
  - Services must be provided in an intermediate mental health/substance use disorder treatment care facility;
  - Lab tests must be related to treatment.

To confirm if an expense is eligible for reimbursement, contact an Anthem customer service associate at the number on the back of your ID card.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law, with a 25% discount if the attorney is retained.

Health Savings Account (HSA)

As a Pre-65 Retiree, you cannot continue to make contributions by means of payroll deduction to the health savings account ("HSA") you established through the Company. However you may continue to contribute to your HSA outside of payroll deduction (or to another health savings account you establish) until you attain age 65, provided you are enrolled in the HDPPO 1 or HDPPO 2 options or other eligible high deductible coverage and you are otherwise eligible under Federal law to contribute to such an account.

If you previously contributed to an HSA through the Company by means of payroll deduction, your HSA contributions made through payroll deduction as well as the Company's contributions to your HSA will stop when you retire. Your account balance goes with you, however, and continues to earn interest. You may continue to use your HSA to pay for future medical expenses during retirement. However, you will be responsible for paying any monthly fees related to the administration of your account. Upon your retirement, your HSA will be converted to a new direct account in your name, and you will receive a new debit card you can use to pay for eligible expenses.

Contact the HSA custodian, UMB, directly at 1-866-520-4472 if you have any questions about your HSA or your debit card after you retire.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB)*" information in the **Benefits Program Overview** section to learn more about the Plan's COB features.

Please Note: If you or your covered dependent are enrolled in Medicare due to end-stage renal disease, and if Medicare is

not already paying as primary, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits.

Filing a Claim

Generally, In-Network Providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained by calling Anthem at the number listed on the back of your ID card.
- Attach copies of all available medical bills that should be considered for Plan benefits. These bills should include:
  - Name of patient;
  - Name and Social Security number of Retiree;
  - Date of treatment;
  - Type of treatment;
  - Charge for the treatment;
  - Provider of the treatment; and
  - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your Benefit Plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 18 months from the date of service generally will not be considered for payment. If you have any questions regarding filing claims, contact Anthem at the number listed on the back of your ID card.

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan."*

Continuation of Coverage

General

For information regarding continuation of coverage under the Pre-65 Retiree Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage.*"

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same Deductibles and Co-Insurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on these benefits, contact the Benefits Source at **1-888-640-3320**.

General Program Information

Program Name:	NiSource Life and Medical Benefits Program
Benefit Plan Name:	NiSource Consolidated Flex Medical Plan (a component of the NiSource Life and Medical Benefits Program)
Plan Type:	Group Health Plan
Plan Number:	536
Type of Funding:	With respect to the PPO and HDPPO Options, self-funded. PPO and HDPPO benefits under the Plan are funded through the general assets of the Participating Employers, through participant contributions and other benefit funding vehicles that may be established from time to time.
Contribution Source:	Retiree and Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the Benefit Plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of Benefit Plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the Benefit Plan and the Claims Administrator. Benefits will be paid under a Benefit Plan only if the applicable Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.
Claims Administrator For Medical, Mental Health and Substance Use Disorders and Pharmacy Benefit Manager (PBM) for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 anthem.com 1-800-228-2891

	Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410 Service of legal process may be made upon the Plan Administrator.

Post-65 Retiree Medical Plan

For Eligible Post-65 Retirees
and/or Eligible Spouses Age 65 and Over

Your Post-65 Retiree Medical Plan Coverage

This is the SPD (the "Post-65 Retiree Medical SPD") for the NiSource Post-65 Retiree Medical Plan, also referred to as the Post-65 Retiree Medical Plan. In this Post-65 Retiree Medical Plan SPD, the Post-65 Retiree Medical Plan is sometimes referred to as the "Plan."

The Company provides to eligible Post-65 Retirees and to their eligible Spouses, as well as to eligible Spouses of Pre-65 Retirees who are covered under the Pre-65 Retiree Medical Plan, the following medical coverage option that is designed to supplement coverage under Medicare:

- NIPSCO Medicare Supplement Option

The following is a description of your coverage under the NiSource Post-65 Retiree Medical Plan.

Eligibility

For information regarding eligibility under the Post-65 Retiree Medical Plan, please see the *"Eligibility under the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan"* subsection of the **Benefits Program Overview**.

Please Note: A Retiree who is rehired by an Employer other than NIPSCO, or who is rehired by NIPSCO other than as an Employee represented by a USW Union, shall lose eligibility for coverage as a Retiree under the Post-65 Retiree Medical Plan (and shall not be eligible for such coverage upon his or her subsequent retirement), but may be eligible for coverage under the NiSource Consolidated Flex Medical Plan while an employee, subject to the terms and conditions for employee coverage under that Benefit Plan. *Please contact the Benefits Source at **1-888-640-3320** to speak to a service representative if you have any questions concerning your eligibility for retiree medical benefits in the event you are rehired as an employee.*

Enrollment

For information regarding enrollment in the Post-65 Retiree Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan"*.

Contributions

Retired employees contribute to the cost of the Plan according to the arrangement in place at the time of retirement. Those covered persons continuing their coverage under COBRA shall contribute an amount required under COBRA. For further information about COBRA see the *COBRA* information in this section of this Handbook. For a discussion of a subsidy that may be available to reduce the cost of your coverage, please see the subsection of the **Benefits Program Overview** entitled *"Defined Dollar Subsidy for Retiree Medical Coverage"*.

Medicare Part B Reimbursement

Eligible Retirees are entitled to a reimbursement of a portion of the cost of their Medicare Part B premium. To obtain the reimbursement, you do not have to enroll in the NIPSCO Medicare Supplement Option. However, you must first provide certain information to the Plan Administrator. Your reimbursement will begin on the first day of the month following the Plan Administrator's receipt of all required information; provided that if you submit all required information and satisfy all other requirements within 60 days of the effective date of your enrollment in Medicare Part B, your reimbursement will begin effective as of the date of your Medicare Part B enrollment. For more information and for details on how to obtain the reimbursement, please call the Benefits Source at **1-888-640-3320**.

Medicare Part D Reimbursement

Eligible Retirees are entitled to a reimbursement of a portion of the cost of their Medicare Part D premium. To obtain the reimbursement, you do not have to enroll in the NIPSCO Medicare Supplement Option. However, you must first provide certain information to the Plan Administrator. Your reimbursement will begin on the first day of the month following the Plan Administrator's receipt of all required information; provided that if you submit all required information and satisfy all other requirements within 60 days of the effective date of your enrollment in Medicare Part D, your reimbursement will begin effective as of the date of your Medicare Part D enrollment. For more information and for details on how to obtain the reimbursement, please call the Benefits Source at **1-888-640-3320**.

ID Card

For information concerning identification cards for the Retiree 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 Retiree Medical Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan"*.

Highlights of the NIPSCO Medicare Supplement Option

The NIPSCO Medicare Supplement Option is designed to pay for certain, although not all, expenses that are eligible and allowable under Medicare, but that are not paid by Medicare due to the application of deductibles and co-insurance percentages. The NIPSCO Medicare Supplement Option shall not cover any charges that are also payable by Medicare.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the date such claim was incurred or the date when the rescission of coverage occurred, as the case may be. For more information, see the *"Claims Determination and Appeal Process – Post-65 Retiree Medical Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 34.

The following is a brief summary of benefits under the NIPSCO Medicare Supplement Option. *This is not a confirmation or guaranty of coverage. Coverage listed below is subject to change*.

General Information for NIPSCO Medicare Supplement Option	
Plan Profile For more information, call Member services	1-800-228-2891
Hours	8:00 am to 8:00 p.m. Eastern Time, M - F
Internet website address Group ID Anthem Package ID	anthem.com 003327107 010

Feature	
Deductible	• **Medicare Part A Services:** The Plan pays the Part A deductible, except for lifetime reserve days. • **Medicare Part B Services:** The Plan pays one hundred percent of the annual Medicare Part B deductible.

Feature/Service	**Plan Pays**
Physician Services	
Office visit (primary care and specialist) and surgical hospital visit	• Plan pays Medicare deductible and up to 20% of Medicare approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details

Feature/Service	Plan Pays
Preventive and Wellness Services	
Routine physical exam	• Not covered
The following preventive or wellness services: • Flu, pneumonia, and hepatitis B shots; • Routine flexible sigmoidoscopy (once every 48 months); • Routine prostate cancer screening (once every 12 months); • Routine gynecological exam (once every 24 months); • Routine Pap smear test (once every 24 months); and • Routine annual mammogram	• Plan pays Medicare deductible and up to 20% of Medicare approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details
Diagnostic Services	
X-rays, allergy tests, and laboratory services	• Plan pays Medicare deductible and up to 20% of Medicare approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details
Outpatient Services	
Surgery	• Plan pays Medicare deductible and up to 20% of Medicare approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details
Emergency Services	
Emergency room	• Plan pays Medicare deductible and up to 20% of Medicare approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details
Hospital Services	
Semi-private room and board	• Plan pays Medicare Part A deductible and 25% of the Medicare–eligible charges not paid by Medicare from days 61-90 of confinement • Contact Anthem for specific benefit details

Feature/Service	Plan Pays
Surgical charges above those covered by Medicare	• 80% of Maximum Allowed Amount, after a $50 Deductible per year, for surgical charges above those covered by Medicare, up to a maximum of $10,000 per year • Contact Anthem for specific benefit details •
X-ray and laboratory services	• Plan pays Medicare Part A deductible • Contact Anthem for specific benefit details
Transplant Services	
Transplant Services	• Up to 20% of Medicare-approved charges for which Medicare pays 80%. Meals are not covered. Benefits for transplant services are limited to $10,000 per covered person per plan year. • Contact Anthem for specific benefit details •
Prescription Drugs*	• There is a 100% co-pay requirement for all prescription drugs. Your ID card may be used to obtain discounts at participating pharmacies.
Mental Health Services	
Inpatient treatment	• After Plan payment of Medicare deductible, Plan pays 80% of charges not covered by Medicare due to Medicare day maximum being exhausted. • Contact Anthem for specific benefit details
Outpatient treatment	• After Plan payment of Medicare deductible, Plan pays 80% of Medicare-approved charges not paid by Medicare. • Contact Anthem for specific benefit details
Substance Use Disorder Services	
Inpatient treatment	• After Plan payment of Medicare deductible, Plan pays 80% of charges not covered by Medicare due to Medicare day maximum being exhausted. • Contact Anthem for specific benefit details
Detoxification	• After Plan payment of Medicare deductible, Plan pays 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

Feature/Service	Plan Pays
	• Contact Anthem for specific benefit details
Outpatient treatment	• After Plan payment of Medicare deductible, Plan pays 80% of Medicare-approved charges not paid by Medicare. • Contact Anthem for specific benefit details
Other Services	
Durable medical equipment	• Plan pays Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details
Vision benefits (diagnostic vision exams only)	• Plan pays Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details
Hearing benefits (only diagnostic hearing exams are covered)	• Plan pays Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80% • Contact Anthem for specific benefit details

*The NIPSCO Medicare Supplement Option does not offer prescription drug coverage. However, as noted, your ID card may be used to obtain discounts at participating pharmacies. Medicare has an optional prescription drug benefit (also known as Medicare part D). This benefit offers coverage for part of the cost of many prescription drugs for Medicare-eligible participants. You may want to consider enrolling in Medicare Part D to receive prescription drug benefits through Medicare. If you are eligible for coverage under Medicare Part D and do not enroll during your initial enrollment period, you may incur significant penalties in the form of higher Medicare premiums when you ultimately do enroll in coverage.

Medical Expenses Not Covered

Without limiting the generality of the foregoing, the medical expenses **not** covered under the Post-65 Retiree Medical Plan include, but may not be limited to those medical expenses that would not be covered by Medicare, 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, and charges incurred prior to the effective date of coverage, or after the termination date of coverage.

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 to File a Claim

Since the Post-65 Retiree Medical Plan is designed to supplement your coverage under Medicare, Medicare is your primary carrier. That means that, as a general rule, your expenses must be submitted to Medicare before they are submitted to the Post-65 Retiree Medical Plan for payment.

Medical expenses are usually submitted to Medicare directly by the provider. However, it is your responsibility to submit your claim to the Plan's Claim Administrator for benefit payments under the Post-65 Retiree Medical Plan.

Some providers, however, may submit your expenses to both Medicare and the Plan for payment. In that event, you would not need to submit any additional claim forms. Please ask your provider whether your claim filing will be submitted to Anthem for your Medicare Supplement benefit payments.

In the event you must submit a claim form to Anthem for your benefit payment, that claim form may be obtained by calling Anthem at the number listed on the back of your ID card. Your Medicare Explanation of Benefits (EOB) must be included when filing a claim with Anthem. If you have any questions relating to your claim filing process, you can call Anthem at the number listed on the back of your ID card. Claim forms should be submitted to:

Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348
anthem.com
1-800-228-2891

Please note that it is essential that you include the Medicare Explanation of Benefits form with your claim form because the Plan's benefits are computed on the basis of what Medicare approved as eligible expense.

Retain copies of all bills and Medicare correspondence for your records.

Below is a list of details that are often erroneously omitted from claim forms. Please refer to it when completing your claim form so you can make sure your claim form is complete.

1. Age and relationship of dependent
2. Physician's statement showing place, date and charge for treatment.
3. Itemized X-ray and laboratory bills showing date, charge and type of examination.
4. Full statement as to how, when and where injury occurred.

No cancelled checks, receipts or summaries of balances due are acceptable as evidence of expense incurred—only itemized statements accompanied by a Medicare Explanation of Benefits form are acceptable. Furthermore, a separate claim form must be completed by you and your physician for each sickness or injury. However, in case of chronic illnesses such as allergies or hypertension, you only must submit one physician's statement each calendar year.

One additional point to keep in mind is that the NISPCO Medicare Supplement Option does not cover prescription drug expenses. However, your ID card may be used to obtain discounts at participating pharmacies.

EAP/Work Life/Legal & Financial Services

Beacon Health Options offers you and your family an Employee Assistance Program (EAP), which provides short term counseling, information, resources, and referrals on a variety of life issues that you may be facing. These issues can include:

- Marital and family relationships
- Finding child care
- Depression and anxiety
- Adopting a child
- Workplace Concerns
- Caring for an elderly parent
- Balancing work and your personal life
- Legal and financial issues

The EAP provides clinical, professional assistance 24 hours a day, seven days a week, 365 days a year at 1-800-946-5360. The EAP is a confidential program available at no cost; you and your household members have up to six (6) sessions per year with an EAP counselor, either in-person, telephonically or via video. Counselors will help you define your needs, and provide counseling, support and referrals as needed. If clinical assistance is needed beyond the six EAP sessions for outpatient or inpatient treatment, you are responsible for the care selected.

You can also call the EAP for Work Life issues, e.g., eldercare and childcare. Extensive searches for information and services compatible with your family's preferences and finances will be provided. Work Life Consultants work hard to find resources that fit your budget requirements. Resource and referral information provided to you is at no cost. However, you are responsible for costs associated with services and businesses with whom you may contract.

Additionally, you can call the EAP for guidance on legal and financial issues including, but not limited to, divorce, domestic violence, criminal, civil, landlord tenant issues, debt management, estate planning, family budgeting, etc. The benefit allows for a free 30-minute consultation with a financial consultant, a 60-minute consultation with an attorney for family law issues and a 35% discount if you retain the attorney, and a free 30-minute consultation with an attorney for legal issues other than family law , with a 25% discount if the attorney is retained.

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 – Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan."*

Continuation of Coverage

For information regarding continuation of coverage under the Post-65 Retiree Medical Plan, including COBRA continuation coverage, please see the subsection of the **Benefits Program Overview** entitled "*Continuation of Coverage under the Pre-65 Retiree Medical Plan and Post-65 Retiree Medical Plan.*"

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.

General Program Information

Program Name:	NiSource Post-65 Retiree Medical Plan
Benefit Plan Name:	NIPSCO Medicare Supplement Option
Type of Plan:	Group Health Plan
Plan Number:	538
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:	Retiree and Employer
Plan Sponsor:	NiSource Inc.
Fiduciary and Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants may 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, Mental Health and Substance Use Disorders and PBM for Prescription Drugs:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 **anthem.com** 1-800-228-2891 Address for Claims Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348

	Address for Mail Order Prescription Drugs: Anthem Blue Cross and Blue Shield Home Delivery Service P.O. Box 94467 Palatine, IL 60094-4467 1-800-228-2891 (mail order)
Claims Administrator for EAP:	Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850 achievesolutions.net 1-800-946-5360
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410 Service of legal process may be made upon the Plan Administrator.

Retiree Life Insurance Plan

Retiree Term Life Coverage -Basic Plan

Your Retiree Life Insurance Option

This is the SPD (the "Retiree Life Insurance SPD") for the Northern Indiana Public Service Company Employee Life Insurance Plan, also referred to as the Retiree Life Insurance Plan. In this Retiree Life Insurance SPD, the Retiree Life Insurance Plan is sometimes referred to as the "Plan."

NiSource Inc. (the "Company") offers the Plan to eligible Retirees with the following coverage option (a "Coverage Option"):

- Basic Retiree Term Life Coverage Option;

Benefits are provided under one or more group insurance contracts (collectively, the "Group Contract") and one or more group insurance certificates (collectively, the "Group Insurance Certificate") issued by Minnesota Life Insurance Company ("Securian"), an affiliate of Securian Financial Group, Inc., who is the Insurer and Claims Administrator and is wholly responsible for the payment of benefits.

If there is a conflict between the Group Contract and Group Insurance Certificate, on the one hand, and this Retiree Life Insurance SPD, 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 Retiree Life Insurance SPD.** *You may obtain a copy of the Group Insurance Certificate by contacting the Benefits Source at **1-888-640-3320**.*

The Plan provides life insurance on the persons of eligible Retirees.

Eligibility

For information regarding eligibility under the Retiree Life Insurance Plan, please see the subsection of the **Benefits Program Overview** entitled *"Eligibility under the Retiree Life Insurance Plan."*

Please Note: A Retiree who is rehired by an Employer other than NIPSCO, or who is rehired by NIPSCO other than as an Employee represented by a USW Union, shall lose eligibility for coverage as a Retiree under the Retiree Life Insurance Plan (and shall not be eligible for such coverage upon his or her subsequent retirement), but may be eligible for coverage under the NiSource Life Insurance Plan while an employee, subject to the terms and conditions for employee coverage under that Benefit Plan. *Please contact the Benefits Source at **1-888-640-3320** to speak to a service representative if you have any questions concerning your eligibility for retiree life insurance benefits in the event you are rehired as an employee.*

*Information regarding eligibility can be accessed through the Benefits Source website, mysourceforhr.com, or by calling the Benefits Source at **1-888-640-3320** to speak to a service representative.*

Enrollment

For information regarding enrollment under the Retiree Life Insurance Plan, please see the subsection of the **Benefits Program Overview** entitled *"Enrollment in the Retiree Life Insurance Plan."*

Contributions

Premium contributions are not required for the Basic Retiree Term Life Coverage Option.

When Coverage Begins and Ends

For information regarding when coverage begins and ends under the Retiree Life Insurance Plan, please see the subsection of the **Benefits Program Overview** entitled *"When Coverage Begins and Ends – Retiree Life Insurance Plan"*.

Beneficiaries and Assignments

Refer to the Group Insurance Certificate for details regarding designation of beneficiaries under the Coverage Option. You can obtain a beneficiary form by calling the Benefits Source at 1-888-640-3320. Securian has prepared information about the modes of settlement that are available. For further information, contact the Benefits Source at 1-888-640-3320.

Insurance under a Coverage Option may not be assigned.

Basic Retiree Term Life Coverage

The Basic Retiree Term Life Coverage Option provides a benefit to your beneficiary or beneficiaries in the amount of $15,000. There is no cash value associated with, or attributable to, the Basic Retiree Term Life Coverage Option.

Please Note*:* No lawsuit or legal action of any kind regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals (but not including any voluntary appeal) has been exhausted. In addition, in no event may any lawsuit or other legal action regarding a claim for benefits be commenced later than three years after the end of the period within which proof of claim is required, unless otherwise provided under Federal law. For more information, see the *"Claims Determination and Appeal Process – Life Insurance Plan"* section of the **Benefits Program Overview**, and in particular the section entitled *"Limitation of Actions and Venue,"* found on page 37.

Option to Accelerate Payment of Death Benefits

If you have a Terminal Condition while insured under the Basic Retiree Term Life Coverage Option (the "Retiree Term Life Insurance"), you may elect to have an Accelerated Benefit paid to you in one lump sum, or in any other manner agreeable to you and Securian, when Securian receives proof satisfactory to it that you have a Terminal Condition.

You have a "Terminal Condition" if you have a condition caused by sickness or accident that directly results in a life expectancy of twelve months or less. Securian must be given evidence that is satisfactory to it that your life expectancy, because of sickness or accident, is twelve months or less. That evidence must include a certification by a physician, other than you or a member of your immediate family, who is licensed to practice medicine or treat illness in the state in which treatment is received. Securian has the right to have you medically examined at its own expense to verify your medical condition. Securian may do this as often as reasonably required while Accelerated Benefits are being considered or paid.

"Accelerated Benefit" means the amount of your Retiree Term Life Insurance that Securian will pay if you are eligible under the Group Insurance Certificate rider with respect to Accelerated Benefits. You must take the entire Accelerated Benefit. Securian calculates the Accelerated Benefit by multiplying your death benefit (the amount of your life insurance as shown on the specifications page attached to the certificate furnished to you by Securian) by the accelerated benefit factor. The accelerated benefit factor will be stated as a percentage of your death benefit. In calculating this factor, Securian considers your age and gender. Securian also bases its calculation of the factor upon certain assumptions, which it may change from time to time, including without limitation assumptions about expected future premiums and your life expectancy. The minimum death benefit eligible for an Accelerated Benefit is $10,000.

If you elect to accelerate the full amount of your death benefit, your Retiree Term Life Insurance coverage and all other benefits under your certificate of insurance and any certificate supplements will end.

Your right to be paid under this option is subject to the following terms: (1) Your Retiree Term Life Insurance must be in force and all premiums due must be fully paid; (2) You must make application in writing and in

a form that is satisfactory to the Claims Administrator; (3) You must be the sole owner of your certificate of insurance; (4) You must not have designated an irrevocable beneficiary for your Retiree Term Life Insurance; (5) You must not be required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; and (6) You must not be required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Please note that any payment of an Accelerated Benefit may be taxable. You should consult your tax advisor for assistance with any questions you may have.

Refer to the Group Insurance Certificate for additional details, terms and conditions regarding this option.

Payment of Death Benefits under Life Coverage

If you die while covered under the Plan, the amount of insurance on you is payable when Securian's home office receives written proof satisfactory to it that you died while covered under the Plan and insured under the Group Insurance Certificate. If you die within 31 days after ceasing to be covered under the Plan, but while you are entitled to convert insurance under the Plan to an individual contract, death benefits in the amount of insurance that could have been converted may be payable when Securian receives written proof as described above.

Death Benefits under the Retiree Term Life Coverage Option are payable according to Securian's beneficiary and mode of settlement rules.

Conversion Privilege for Life Coverage

If all or a part of your Retiree Term Life Insurance terminates because you move from one existing eligible class to another, or you are no longer in an eligible class, you may convert up to the full amount of terminated insurance.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because (1) the Group Contract is terminated; or (2) the Group Contract is changed to reduce or terminate your insurance. In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of: (a) $10,000; and (b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by Securian or any other carrier within 31 days of the date the insurance terminated under the Group Contract.

Neither the conversion right nor the limited conversion right is available if your coverage under the Plan or Group Contract terminates due to failure to make, when due, required premium contributions. Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by Securian for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

See the "*Highlights of Conversion and Portability Features*" below for additional details regarding the conversion privilege. Also, refer to the Group Insurance Certificate for additional details, terms and conditions.

Highlights of Conversion and Portability Features

	Conversion	Portability
Can Basic Retiree Term Life Coverage be converted or ported?	Yes	No
Coverage can be converted or ported to:	Individual Life Policy	Not applicable
Evidence of Insurability Required	No	Not applicable
Application Deadline	Application and first month premium due 31 days after your coverage termination.	Not applicable
Securian Contacts	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 Robert Street North St. Paul, MN 55101-2098	Not applicable

Conformity with State Law

If any provision of this Retiree Life Insurance SPD 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.

Claim forms are available from Securian. Claim forms can be obtained from Securian by phone via the Benefits Source at ***1-888-640-3320****, or online via the Benefits Source website at* **mysourceforhr.com**. *If you do not receive the form from Securian within 15 days of your request, send Securian written proof of claim without waiting for the form.*

Claim Determination and Appeal Process

For information regarding the Plan's claim determination and appeal process, please see the subsection of the **Benefits Program Overview** entitled *"Claim Determination and Appeal Process – Retiree Life Insurance Plan."*

General Program Information

Program Name:	NiSource Welfare Benefits Program
Benefit Plan Name:	Northern Indiana Public Service Company Employee Life Insurance Plan (a component of the NiSource Welfare Benefits Program)
Type of Plan:	Employee Welfare Benefit Plan providing life insurance benefits
Plan Number:	537
Contribution Source:	Basic Retiree Term Life Insurance: Employer
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410
Plan Administrator:	NiSource Benefits Committee 801 East 86th Avenue Merrillville, Indiana 46410 (219) 647-4334
EIN:	35-2108964
Plan Year:	January 1 through December 31
Type of Administration:	Fully Insured. The Plan is insured under a group insurance contract underwritten by the Insurer.
Insurer:	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 North Robert Street St. Paul, MN 55101
Claims Administrator: (if you need to submit a claim)	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. 400 Robert Street North St. Paul, MN 55101-2098
Agent for Service of Legal Process:	Manager, Benefits Accounting & Compliance 801 East 86th Avenue Merrillville, Indiana 46410 Service of legal process may be made upon the Plan Administrator.

The Group Contract underwritten by Minnesota Life Insurance Company provides insured benefits under the Plan. Minnesota Life Insurance Company ("Securian") is an affiliate of Securian Financial Group, Inc. Plan benefits are provided under the terms of the Group Contract and the Group Insurance Certificate. In the event of a conflict between this Retiree Life Insurance SPD and the Group Contract and Group Insurance Certificate, the terms of the Group Contract and Group Insurance Certificate shall prevail. The Group Insurance Certificate is available upon request by calling the Benefits Source automated telephone system at **1-888-640-3320** and asking to speak to a service representative.

Securian, as Claims Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. Benefits under the Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.