NiSource®

EMPLOYEE BENEFITS

2024

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NiSource is proud to support our employees' overall wellbeing with a variety of benefit options. This guide offers details on our 2024 offerings for you and your family. Contact the Benefits Source with any questions.

See page 27 for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to NiSource, Inc. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

WELCOME

Now is the Time to Enroll!

October 23 – November 3, 2023

This guide is designed to assist you and your family in making the best choices for your needs in 2024. It contains explanations of each benefit, and contact information for benefits vendors, you can expect for each benefit. Please review this guide in its entirety and keep as a resource throughout the year.

To be your healthiest and help keep costs down, we ask that you take advantage of the provided wellness activities and preventive features.

What's Changing this Year?

- For 2024, the IRS defines a high deductible health plan (HDHP) as any plan with a deductible of at least $1,600 for an individual or $3,200 for a family.
- Hinge Health — Effective January 1, 2024, Anthem members will have access to Hinge Health. Hinge Health is a digital musculoskeltal treatment program which combines expert clinical care and advanced technology to go beyond traditional physical therapy. This new benefit will be available at no cost to you through the NiSource health plans. More information will be coming in 2024. If you have additional questions, contact Anthem at the number on the back of your medical card.
- Spending Accounts Change — On January 1, 2024, Your Spending Account™ (YSA) will transition to Smart-Choice Accounts and offer an enhanced online and mobile experience. As we move to the new Smart-Choice experience, you'll receive more information on conversion details, required action items, and important dates.
- During Annual Enrollment, you will be prompted to update your delivery preference information (either email or postal mail) and make updates as needed by clicking the "Manage Communications" button.

Any Questions?

We're here to help. Contact the Benefits Source at 888-640-3320.

Annual Enrollment Action Items

Update your personal information and email preference.

- During Annual Enrollment, you will be prompted to update your communication preferences and enter your preferred email.
- Confirm your mailing address and phone number are up to date.
- It is also a great time to ensure your beneficiary information is up to date.

Double-check covered medications.

- If you make any changes to your plan, consider how it affects your prescriptions (i.e. will their costs go up or down?)

Review available plans' deductibles.

- This year, the HD PPO 1 deductible will increase to meet IRS guidelines.
- Think you may have more medical needs than usual this year? You might want a lower deductible. If not, you could switch to a higher deductible plan and enjoy lower monthly premiums.

Consider your HSA or FSA and remember you must enroll each year to have this benefit.

- A Health Savings Account (HSA) or Flexible Spending Account (FSA) can help cover healthcare costs, including dental and vision services and prescriptions.
- Adding one of these accounts to your benefits can help with your long-term financial goals.

Check your networks.

- Receiving care by in-network providers often saves you money.
- Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.

ELIGIBILITY AND ENROLLMENT

NiSource's benefits are designed to support your unique needs.

Eligibility

If you are a full time or part time* non-union employee of NiSource, you are eligible to participate in the benefit plans outlined in this guide. Please review carefully and contact the Benefits Source for questions about your specific coverage and rates.

Coverage Dates

Your elections are effective January 1, 2024 or the first day of employment for new hires. Benefits cannot be changed until the next Annual Enrollment period unless you experience a qualifying life event.

NOTE

NiSource reserves the right to audit your current covered dependents who have not been verified to confirm they are eligible for coverage.

In addition, beginning Q2, NiSource will begin to request that new dependents added to your coverage will be required to be verified at the time of enrollment or change. If you have questions about eligibility, please contact the Benefits Source.

Dependents

Dependents you may cover under a NiSource group health plan include:

- Your lawful spouse, if not legally separated, who is also a "spouse" under the Internal Revenue Code (IRC)
- Your former spouse or your spouse from whom you are legally separated, but only with respect to insured medical plan coverage that is provided under a policy of health insurance or pursuant to a contract with a health maintenance organization, and only to the extent and for as long as such coverage is required by applicable state law
- Your eligible child** who has not attained 26 years of age
- Your eligible child** who is over age 26, if he or she satisfies the criteria for coverage as a disabled child and has been approved by the healthcare plan (please note, however, that a child is not eligible for coverage under the Post-65 Retiree Medical Plan)

For additional details, refer to the Dependent Eligibility Rules under the Plan Information page.

*Please note, benefits may vary for part-time employees. For questions about your eligibility for specific benefits, please log on to **mysourceforhr.com**.
For specific details on "eligible child," please ensure you review the Dependent Eligibility Rules document during Annual Enrollment or under the Plan Information page on **mysourceforhr.com.

What are Qualifying Life Events?

You can update your benefits when you start a new job or during Annual Enrollment each year. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health coverage or make changes outside of these times.

When a Qualifying Life Event occurs, you have 31 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)

- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (**Healthcare.gov**)
- Changes in address or location that may affect coverage
- Turning 26 and losing coverage through a parent's plan

- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to the Benefits Source with questions regarding specific qualifying life events and your ability to request changes. Don't miss out on a chance to update your benefits!

MEDICAL BENEFITS

Medical benefits are provided through Anthem. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind your choice is effective for the entire 2024 plan year unless you have a qualifying life event.

Medical Plan Summary

This chart summarizes the 2024 medical coverage provided by Anthem. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PPO		HD PPO 1		HD PPO 2	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$500	$1,000	$1,600	$3,000	$2,500	$5,000
INDIVIDUAL + SPOUSE/ INDIVIDUAL + CHILDREN	$1,000	$2,000	$3,200	$6,000	$5,000	$10,000
FAMILY	$1,500	$3,000	$3,200	$6,000	$5,000	$10,000
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	60%*	80%*	60%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$1,500	$3,000	$3,000	$6,000	$5,000	$10,000
INDIVIDUAL + SPOUSE/ INDIVIDUAL + CHILDREN	$3,000	$6,000	$6,000	$12,000	$10,000**	$20,000
FAMILY	$4,500	$9,000	$6,000	$12,000	$10,000**	$20,000
COPAYS/COINSURANCE						
PREVENTIVE CARE	No charge	40%*	No charge	No charge	No charge	No charge
PRIMARY CARE	$35	40%*	20%*	40%*	20%*	40%*
SPECIALIST SERVICES	$40	40%*	20%*	40%*	20%*	40%*
DIAGNOSTIC CARE	20%*	40%*	20%*	40%*	20%*	40%*
MENTAL HEALTH – INPATIENT	20%*	40%*	20%*	40%*	20%*	40%*
MENTAL HEALTH – OUTPATIENT	$35	40%*	20%*	40%*	20%*	40%*
URGENT CARE	$35	20%*	20%*	40%*	20%*	40%*
EMERGENCY ROOM (Not followed by admission)	100% covered after $150 copay for accidents (true emergencies); 20%* otherwise		20%*	20%*	20%*	20%*

*After deductible

**Each individual family member may be subject to an out-of-pocket limit that is less than the total $10,000 out-of-pocket limit. See SPD for details.

The individual deductible amount must be met by each member enrolled in the PPO Plan. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the family deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the family deductible amount. The same typically applies for the out-of-pocket maximum.

Each covered individual is not required to meet the individual deductible. The HD PPOs have an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Anthem. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at **Anthem.com** or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty Drugs.

	PPO	HD PPO I		HD PPO 2	
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)					
GENERIC	20%, $5 minimum copay up to $15 maximum copay per prescription	20%*	40%*	20%*	40%*
PREFERRED	20%, $15 minimum copay up to $45 maximum copay per prescription	20%*	40%*	20%*	40%*
NON-PREFERRED	20%, $30 minimum copay up to $90 maximum copay per prescription	20%*	40%*	20%*	40%*
SPECIALTY DRUGS	Covered same as any other drug	20%*	40%*	20%*	40%*
MAIL ORDER RX (90-DAY SUPPLY)					
GENERIC	$20 per prescription	20%*	40%*	20%*	40%*
PREFERRED	$60 per prescription	20%*	40%*	20%*	40%*
NON-PREFERRED	$120 per prescription	20%*	40%*	20%*	40%*
SPECIALTY DRUGS	Covered same as any other drug	20%*	40%*	20%*	40%*

*After deductible

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they are held to the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, contact Anthem using the number on the back of your ID card. Please note, if you or your doctor requests a branded drug when a generic is available, you may pay the difference in cost.

HOW TO PICK A PLAN

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How Does a PPO (Preferred Provider Organization) Work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for services.
- If you or your dependent(s) expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

How Does an HDHP (High Deductible Health Plan) Work?

- You'll pay less in premiums. (Think less money from your paycheck.)
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

Estimate Your Future Medical Expenses

As part of your Annual Enrollment, you will have access to the medical estimator tool by selecting "Personalize Estimates" in the online enrollment flow. The tool will provide a medical plan suggestion and plan comparisons based in part on an estimate of your future medical expenses. Using national averages, you will receive a general estimate, or you can provide more information for a more personalized estimate. To access the tool, simply visit **mysourceforhr.com** and begin the Annual Enrollment process.

How to Find Care

As an Anthem member, you have tools to find care and estimate costs before appointments. Locate doctors, hospitals, labs, and other providers in your plan by contacting Anthem. Your benefits also include access to virtual visits with doctors and other healthcare professionals.

Several convenient ways to access these tools:

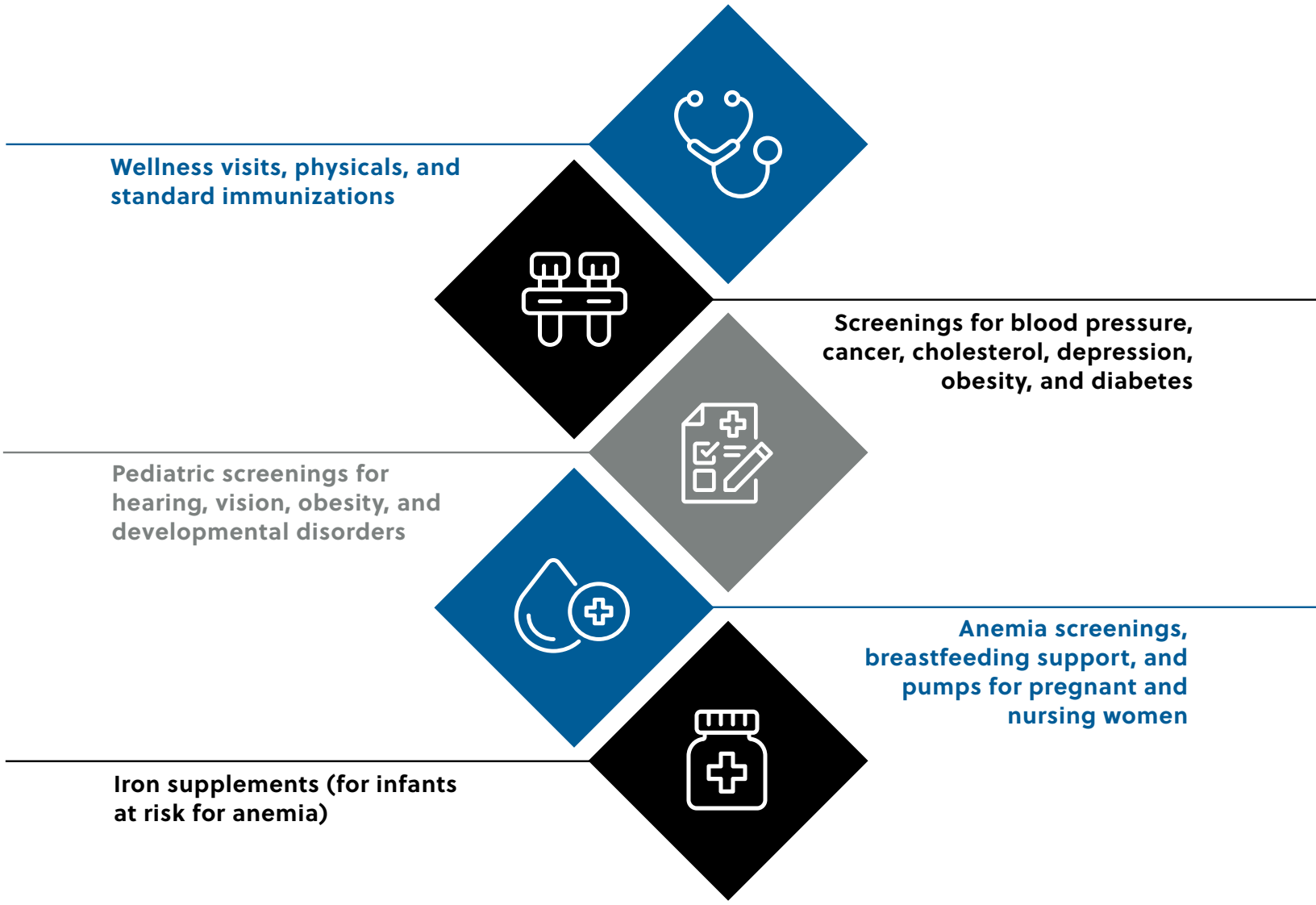
- Call an Anthem Health Guide at 800-228-2891. The trained customer service team is ready to help you Monday through Friday, 8 a.m. to 8 p.m. ET.
- Download the Sydney Health mobile app, which provides you one convenient place to access all of your benefits and easily find care. You can download Sydney Health from the App Store® or Google Play™ from your smart phone.
- Visit **anthem.com** to find detailed information about your healthcare benefits and search for a provider or facility.

NOTE

To get the most value out of your medical plan, be sure to visit in-network providers whenever possible.

PREVENTIVE CARE

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:



It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your Summary Plan Description (SPD) to see what specific preventive services are provided to you.

What vaccines are covered 100% under preventive care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles, and tetanus. For a full list, visit **www.healthcare.gov/preventive-care-adults/**.

Included with your medical coverage, at no cost to you, are one in-network colonoscopy and one in-network mammogram per year regardless of diagnosis (preventive or non-preventive).

Wellness Day

NiSource continues to offer a Wellness Day — additional paid time off — for eligible employees to receive an annual checkup and preventive health screenings. For more information, visit the MySource Benefits & Wellbeing page.

WHERE TO GO FOR CARE

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

 NURSE LINE	 TELEMEDICINE ($)	 PRIMARY CARE CENTER ($)
WHEN TO USE You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.	**WHEN TO USE** You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).	**WHEN TO USE** You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.
TYPES OF CARE* Answers to questions regarding: ▪ Symptoms ▪ Self-care/home treatments ▪ Medications and side effects ▪ When to seek care	**TYPES OF CARE*** ▪ Cold & flu symptoms ▪ Bronchitis ▪ Urinary tract infection ▪ Sinus problems	**TYPES OF CARE*** ▪ Routine checkups ▪ Immunizations ▪ Preventive services ▪ Managing your general health
COSTS AND TIME CONSIDERATIONS** ▪ Usually available 24 hours a day, 7 days a week ▪ Typically free as part of your medical insurance	**COSTS AND TIME CONSIDERATIONS**** ▪ Usually a first-time consultation fee and a flat fee or copay for any visit thereafter ▪ Typically immediate access to care ▪ Prescriptions through telemedicine or virtual visits not allowed in all states	**COSTS AND TIME CONSIDERATIONS**** ▪ Often requires a copay and/or coinsurance ▪ Normally requires an appointment ▪ Short wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

DO YOUR HOMEWORK

What may seem like an urgent care center might actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER ($$)

WHEN TO USE

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

TYPES OF CARE*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns

COSTS AND TIME CONSIDERATIONS**

- Copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but urgency determines order seen and wait time

EMERGENCY ROOM ($$$)

WHEN TO USE

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

TYPES OF CARE*

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injury

COSTS AND TIME CONSIDERATIONS**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

VIRTUAL CARE

When you're under the weather, there's no place like home, and if you're busy with work and family, scheduling an in-person doctor's appointment can be a pain. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

NiSource provides virtual care benefits for you and your dependents through Anthem LiveHealth Online. Anthem LiveHealth Online offers on-demand access to board-certified doctors or therapists through virtual visits using your smartphone, tablet, or computer with a webcam.

Anthem LiveHealth Online doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Bladder infection/ urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomachache
- Sinus problems

You may also make an appointment with a therapist or psychologist if you're feeling anxious or having a tough time. Evening and weekend appointments are available.

Access Virtual Visits

Go to **anthem.com** > Virtual Care to get started, or use the Sydney Health app. Go to Sydney Health > Care > Video visit. After you register and request an appointment, you'll pay your portion of the service costs and enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

Anthem LiveHealth Online doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, use the below QR code to download the Sydney Health app.

NOTE

A virtual visit directly with your primary care physician (vs. Anthem LiveHealth Online) might also be an option — and typically costs the same as an office visit.

HEALTH SAVINGS ACCOUNT

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Alight Solutions is the administrator of your Health Savings Account and UMB is the bank that will manage your HSA. UMB Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on **www.irs.gov** for a complete list.

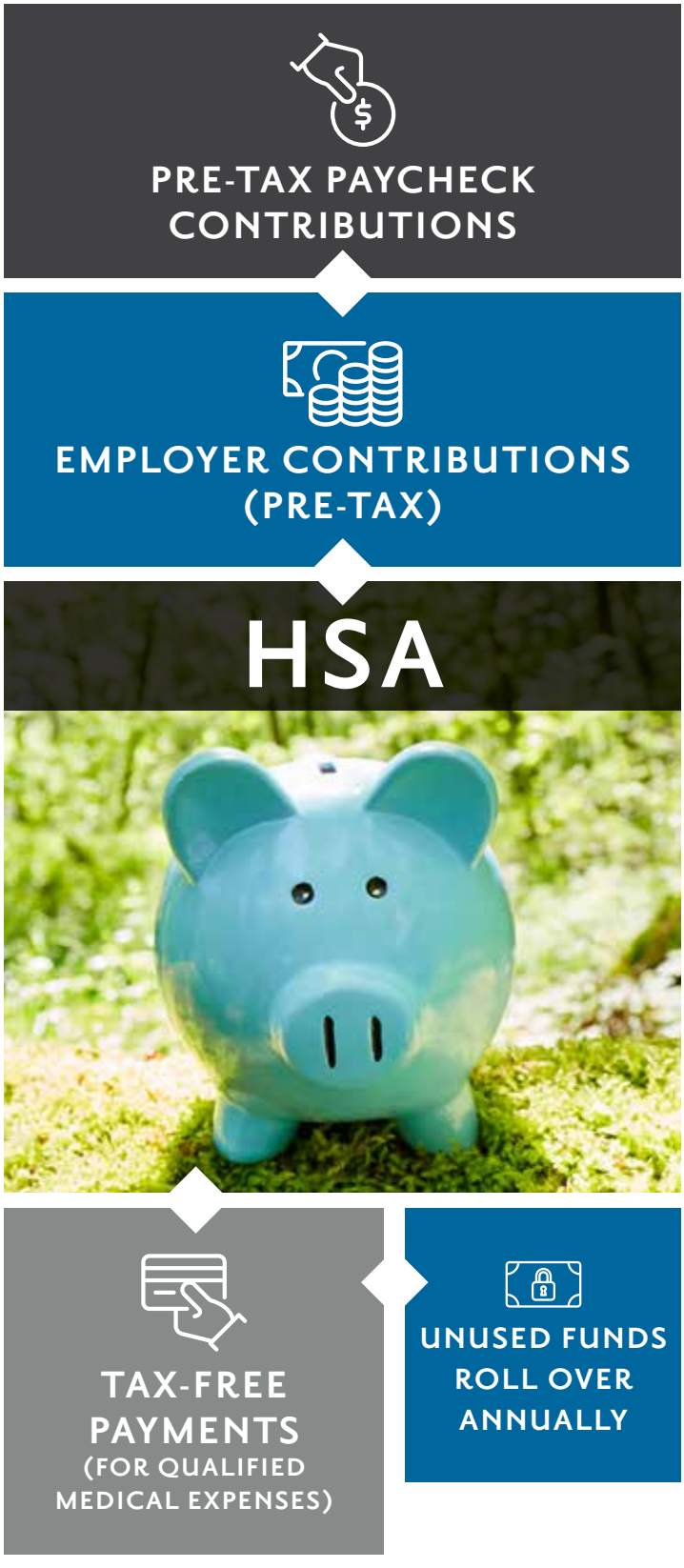
Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

NOTE

Because HSA funds never expire, contributing the annual maximum to your HSA can help you save to pay for healthcare expenses tax free after retirement.



You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

Your HSA is administered by Alight Solutions' Smart-Choice Accounts™. UMB is the bank that will manage your HSA account.

How to Enroll

To enroll in NiSource's HSA, you must elect the HDHP with NiSource. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. NiSource will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with UMB. The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2024, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,150
FAMILY	$8,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

NiSource provides an HSA employer contribution that will be deposited on an annual basis. Amounts will be pro-rated if joining mid-year.

EMPLOYER HSA CONTRIBUTION	
HD PPO 1	$1,200
HD PPO 2	$700

HSA contributions over the IRS annual contribution limits ($4,150 for individual coverage and $8,300 for family coverage for 2024) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The NiSource HSA is established with Alight Solutions. You may be able to roll over funds from another HSA. For more enrollment information, contact the Benefits Source or visit **mysourceforhr.com**.

NOTE

***State income taxes are also waived on HSA contributions in almost all states.**

FLEXIBLE SPENDING ACCOUNTS

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3,050 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Your FSA account(s) are administered by Alight Solutions' Smart-Choice Accounts™.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact Alight Solutions with reimbursement questions. If you need to submit a receipt, Alight Solutions will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2024 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $150,000 or more last year) may have different FSA contribution limits. Visit **www.irs.gov** for more info.

NOTE

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

FSA vs HSA

FLEXIBLE SPENDING ACCOUNTS		HEALTH SAVINGS ACCOUNTS
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	TAXATION	HSA contributions are tax free; the account grows tax free; and funds are spent tax free on qualified expenses.
You can contribute up to $3,050 in 2024 to an FSA. This amount may be increased annually.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,150 combined in 2024 (up to $8,300 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at **www.irs.gov**.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at **www.irs.gov**.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care).	OTHER TYPES	N/A

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

DENTAL BENEFITS

Like brushing and flossing, visiting your dentist is an essential part of your oral health. NiSource offers affordable plan options from Cigna for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Cigna at **mycigna.com**.

Dental Plan Summary

This chart summarizes the dental coverage provided by Cigna for 2024.

	PREVENTIVE DENTAL		DENTAL		DENTAL PLUS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$75	$75	$50	$50	$0	$0
FAMILY	$225	$225	$150	$150	$0	$0
ANNUAL MAXIMUM						
PER PERSON	$2,000	$2,000	Unlimited	Unlimited	$2,000	$2,000
COVERED SERVICES						
PREVENTIVE SERVICES	100%	100%	100%	100%	100%	100%
BASIC SERVICES	50%*	50%*	80%*	80%*	80%*	80%*
MAJOR SERVICES (Dentures/Bridges)	Not covered		50%*	50%*	50%*	50%*
ORTHODONTICS	Not covered		Not covered		50%*	50%*
ORTHODONTIC LIFETIME MAXIMUM					$1,500	$1,500

*After deductible

NOTE

In addition to keeping your teeth healthy, regular dental checkups can help dentists spot symptoms of other serious conditions such as osteoporosis, cancer, and diabetes.

VISION BENEFITS

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through VSP.

Vision Plan Summary

This chart summarizes the vision coverage provided by VSP for 2024.

	VISION PLAN (CHOICE FLEX PLAN)		BASIC VISION (CHOICE EXAM PLUS)	
	IN-NETWORK	FREQUENCY	IN-NETWORK	FREQUENCY
EXAMS				
COPAY	$0	Every calendar year	$0	Every calendar year
FRAMES				
WIDE SELECTION FRAME RETAIL ALLOWANCE	$200; 20% off overage	Adults: Every other calendar year Children: Every calendar year	Discounts available	N/A
FEATURED FRAME RETAIL ALLOWANCE	$250; 20% off overage			
COSTCO FRAME ALLOWANCE	$110			
WALMART/SAM'S FRAME ALLOWANCE	$110/$200			
CONTACTS (IN LIEU OF LENSES AND FRAMES)				
ELECTIVE	$175 allowance for contacts in lieu of glasses; 15% off contact lens exam up to $50 max copay	Every calendar year	15% discount on contact lens fitting and evaluation exam	N/A
MEDICALLY NECESSARY	Covered in full			
LENSES				
SINGLE VISION	100% covered	Every calendar year	No coverage	N/A
KIDS CARE COVERAGE				
EXAM	$0 copay	Two exams every year	$0 copay	Two exams every year
FRAMES/LENSES/CONTACTS	One frame and lenses or contacts every year, and an additional pair of lenses if there's a prescription change		No coverage	

	VISION PLAN (CHOICE FLEX PLAN)	BASIC VISION (CHOICE EXAM PLUS)
	OUT-OF-NETWORK	OUT-OF-NETWORK
OUT-OF-NETWORK ALLOWANCES		
EXAM	$45	$45
SINGLE VISION LENSES	$30	N/A
BIFOCAL LENSES	$50	N/A
TRIFOCAL LENSES	$65	N/A
LENTICULAR LENSES	$100	N/A
FRAME	$70	N/A
ELECTIVE CONTACT LENSES	$105	N/A
MEDICALLY NECESSARY CONTACT LENSES	$210	N/A

LIFE INSURANCE

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

NiSource provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through Prudential, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

Full-time and part-time non-union employees automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. You receive the benefit payment for a dependent's death under the insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact the Benefits Source or your own legal counsel with any questions.

Supplemental Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Supplemental Life and AD&D Insurance. Premiums are paid through payroll deductions.

Calculate Your Needs

Use Securian's online benefits-decision tool, Benefit Scout®, to learn more about your insurance options, ask questions, and determine your needs. Visit **LifeBenefits.com/NiSourceFTE**.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	2x annual salary
WHO PAYS	NiSource
MAXIMUM BENEFIT	$1,500,000
SUPPLEMENTAL EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	Up to 7x annual salary
WHO PAYS	Employee
MAXIMUM BENEFIT	$1,500,000 including Basic Life Coverage
SPOUSE LIFE	
COVERAGE AMOUNT	$10,000 / $25,000 / $50,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$50,000
CHILD LIFE	
COVERAGE AMOUNT	$5,000 / $10.000
WHO PAYS	Employee
MAXIMUM BENEFIT	$10,000 per child

In some options above, you may be asked to complete Evidence of Insurability (EOI) to obtain coverage.

INCOME PROTECTION

You and your loved ones depend on your regular income. That's why NiSource offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Basic Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available at no cost and are administered through ESIS. This insurance replaces up to 100% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your SPD for specific details.

Buy-Up Long Term Disability (LTD) Insurance

NiSource provides 50% of base pay coverage at no cost. You'll have the option to buy up an additional 10% during the annual enrollment period each year and have convenient payroll deductions. This benefit is offered through Prudential. For additional information on this benefit, see your SPD.

RETIREMENT PLANNING

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

Contributing to a 401(k) account now can help keep you financially secure later in life. The NiSource Inc. Retirement Savings Plan provides you with the tools you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	NiSource Inc. Retirement Savings Plan
RECORDKEEPER	Fidelity
WEBSITE	**netbenefits.com**
ELIGIBILITY	First day of employment
COMPANY MATCH	The NiSource 401(k) plan offers a company match on your combined pre-tax, after-tax,and/or Roth after-tax contributions up to 6% of eligible pay.

All About 401(k)

This employer-sponsored retirement account can help your future self by saving money — tax free — from your paycheck. The sooner you participate in a 401(k), the more time your assets have to grow.

Eligible employees can invest for retirement while receiving tax advantages. The NiSource Inc. Retirement Savings Plan offers a company match on your combined pre-tax, after-tax, and/or Roth after-tax contributions up to 6% of eligible pay. Note that the Company does not match any catch-up contributions. Administrative services are provided by Fidelity. There is no waiting period and you may start making contributions into the plan the first day of employment. You must be at least 18 years of age to be eligible.

Pre-tax vs. After-tax vs. Roth 401(k): What's the difference? If you contribute to your 401(k) pre-tax, your contributions are taken out before taxes each pay period, which will lower your annual taxable income. Pre-tax contributions grow on a tax-deferred basis and you won't pay taxes on these dollars until a distribution is taken at retirement. You can also choose to make after-tax contributions into the plan. There are two after-tax options: regular after-tax and Roth. Both options are deducted from your paycheck after taxes; however, they are treated differently. With regular after-tax contributions, the earnings on these contributions are taxable when withdrawn, but the actual contribution is not. If you choose to make Roth contributions into the plan, both the contribution AND the earnings are tax free when withdrawn at retirement — as long as the withdrawal is a qualified one. A qualified withdrawal is one that can be taken five tax years after the year of the first Roth contribution and after you have attained age 59½.

The current elective deferral limit, set annually by the IRS, is $22,500 for 2023.

If you are age 50 or older this year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit accelerates your progress toward your retirement goals. The current maximum catch-up contribution is $7,500 for 2023 — for a combined total contribution allowance of $30,000.

Not sure if you're getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. However, you will need to know how much you contributed at your previous employer so you can factor that in when making your election for the current year and avoid penalties for over contributing.

How Much Should I Save?

Industry standards suggest saving at least 12% to 15% of your income, including NiSource's generous matching contribution on your combined pre-tax, after-tax, and/or Roth after-tax contributions. If you can't afford to save that much, make sure to save up to the matching amount so you don't leave free money behind.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Contact Fidelity at 800-305-4015 for details.

Regardless of which type of contributions you choose or how much you contribute, remember to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and you may be subject to early withdrawal penalties from the IRS.

Investing in the Plan

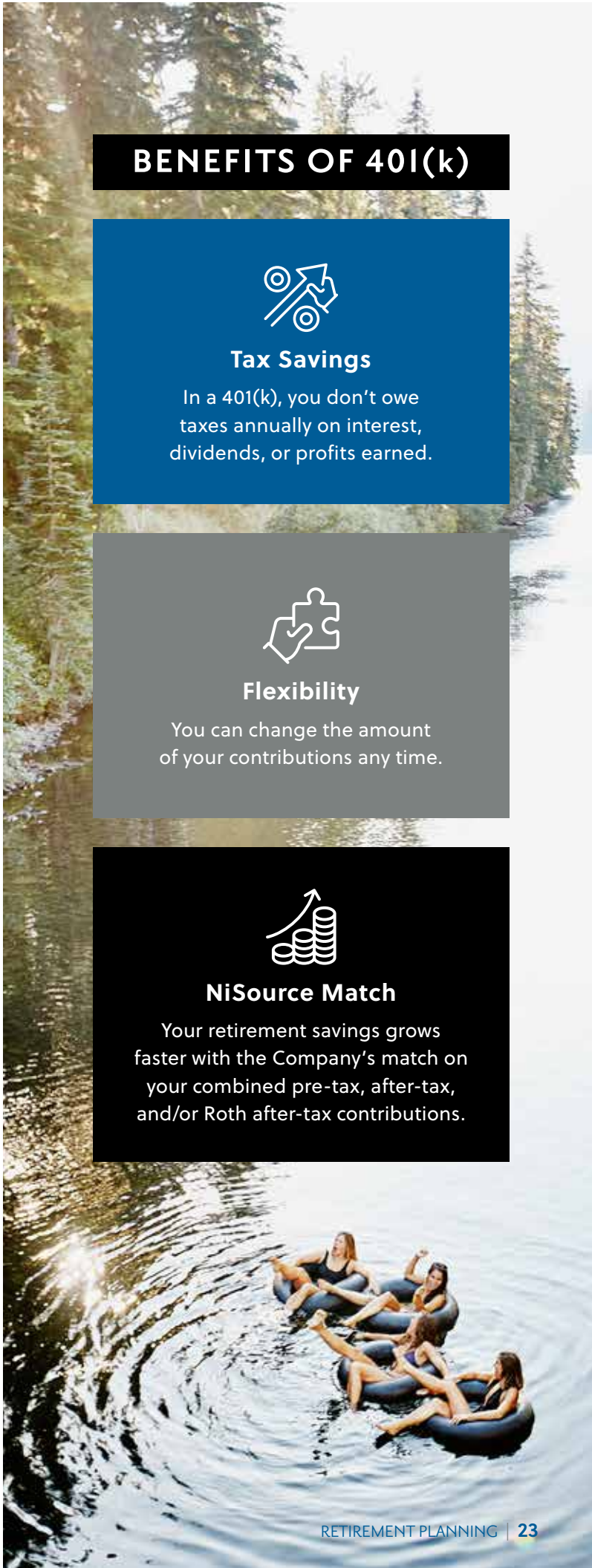
It's up to you how to invest the assets. The NiSource 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, visit **netbenefits.com**.

Vesting

Vesting refers to how much of your 401(k) funds you can take with you if or when you leave NiSource. You are always 100% immediately vested in your entire account.

Designate Your Beneficiary

When was the last time you reviewed your beneficiary? Well, if its been a while or you've experienced a life-changing event such as a marriage, divorce, birth of a child, or a death in the family, then it's time to consider your beneficiary designations. Fidelity's Online Beneficiaries Service offers a straightforward, convenient process that takes just minutes. Simply log on to **netbenefits.com**, click on the "Profile" link, then select "Beneficiaries" and follow the online instructions.



BENEFITS OF 401(k)

Tax Savings

In a 401(k), you don't owe taxes annually on interest, dividends, or profits earned.

Flexibility

You can change the amount of your contributions any time.

NiSource Match

Your retirement savings grows faster with the Company's match on your combined pre-tax, after-tax, and/or Roth after-tax contributions.

NISOURCE WELLBEING HUB

NiSource Wellbeing Hub

The **NiSource Wellbeing Hub** is our internal site to assist you in learning about the tools available to you and your family. From your Mental Health to supporting your Community, we have benefits to assist you.

Employee Assistance Program

We're here for you when you need help. Beacon Health Options, our Employee Assistance Program (EAP), helps you and your family manage your total health, including mental, emotional, and physical. And there's no cost to you — whether you're enrolled in a company-sponsored medical plan or not.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone and a designated number of face-to-face visits per issue with a licensed professional.

All services provided are confidential and will not be shared with NiSource. You may access information, benefits, educational materials, and more by phone at 800-946-5360 or online at **achievesolutions.net/nisource**.

Mental Health Toolkit

NiSource is focused on your whole health. From getting care when you are sick to focusing on wellness to keep you strong, your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help?

If you need work-life balance or need help coping with anxiety, this Toolkit offers the resources you need.

Physical Health Toolkit

Staying healthy goes beyond keeping up with doctors' appointments. It includes eating right, staying active, and being proactive with your overall wellbeing. Take advantage of the programs and discounts offered by our carrier partners.

Financial Health Toolkit

Managing money. It's not always easy to think or talk about, but it's a key building block to success in life. Most people know they could do better handling their money, but finances can be intimidating. This toolkit will help get you started, as well as highlight the financial benefits offered by NiSource.

Community Toolkit

Employee volunteerism provides important development and learning opportunities and builds stronger relationships with the communities where we work and live. Dollars for Doers is a corporate-wide program designed to recognize employee volunteerism efforts through financial contributions to eligible 501(c)(3) nonprofit organizations where NiSource employees volunteer their personal time.

NiSource Wellbeing Hub

Mental Health Toolkit

Physical Health Toolkit

Financial Health Toolkit

Community Toolkit

GLOSSARY

Annual Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

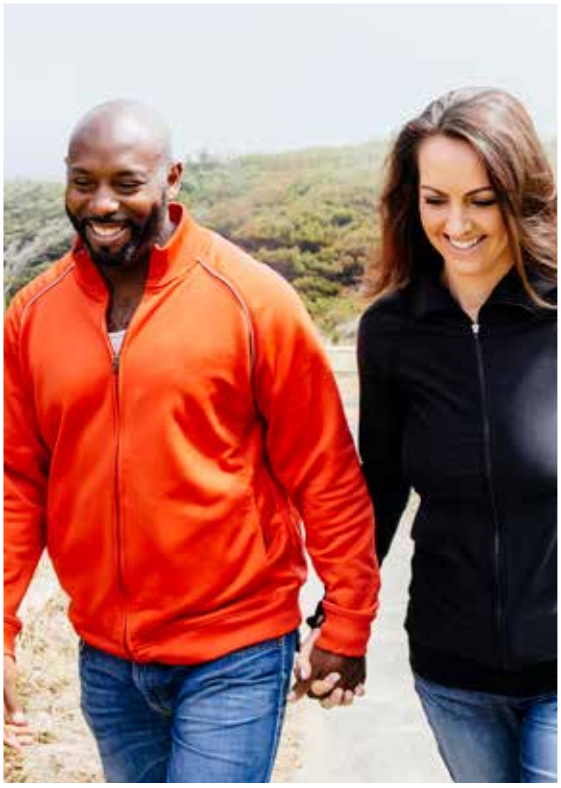
Minimum Essential Coverage Plan – Covers 100% of the cost of certain preventive services, when delivered by a network provider. Helps cover the costs of certain medical expenses incurred due to an accident or sickness at a specified benefit amount for a limited number of days per year.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.



Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from NiSource, Inc. About Your Prescription Drug Coverage and Medicare under the NiSource Life and Medical Benefits Program Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NiSource, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. NiSource, Inc. has determined that the prescription drug coverage offered by the NiSource Life and Medical Benefits Program plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current NiSource, Inc. coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with NiSource, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NiSource, Inc. changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	NiSource, Inc.
Contact—Position/Office:	The Benefits Source
Address:	801 East 86th Avenue Merrillville, IN 46410
Phone Number:	888-640-3320

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact the Benefits Source at 888-640-3320.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Benefits Source at 888-640-3320.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Source at 888-640-3320.

Illinois Essential Health Benefit (EHB) Listing

Employer Name:	NiSource, Inc.
Employer State of Situs:	Indiana
Name of Issuer:	Anthem, Cigna, VSP
Plan Marketing Name:	Anthem Non-Union PPO, Anthem HD PPO 1, Anthem HD PPO 2, Cigna Preventive Dental, Cigna Dental, Cigna Dental Plus, VSP Vision
Plan Year:	2024

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone Anchored Hearing Aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23-24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15-16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (Vasectomy Men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services(Includes MH/SUD Emergency)	Emergency Services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24-25	Yes
17	Reconstructive Surgery		Pgs. 25-26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants – Human Organ Transplants (Including Transportation & Lodging)		Pgs. 18 & 31	Yes

2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory Services	Pgs. 6 & 12	Yes
22	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8-9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory Acute and Chronic Pain Medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See All Kids Pediatric Dental Document	No
29	Pediatric Vision Coverage		Pgs. 26-27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription Drugs	Pgs. 29-34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31-32	Yes
36	Mammography – Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis – Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/Prostate – Specific Antigen Tests/Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (Women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12-13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

IMPORTANT CONTACTS

BENEFIT		CONTACT INFORMATION	PERSONALIZED SUPPORT
Anthem	Medical & Pharmacy	▪ **Anthem.com** ▪ Sydney Health App ▪ 800-228-2891 ▪ Monday through Friday 8 a.m. to 8 p.m. ET	Get concierge service through the Total Health Total You program (including): ▪ Reach a Health Guide ▪ Access virtual care ▪ View digital ID card ▪ Get support on claims, finding care, and much more
Anthem	Telemedicine	▪ Via the Sydney Health App or **livehealthonline.com** ▪ 800-228-2891	Download the Sydney Health app
Cigna	Dental	▪ **mycigna.com**	
VSP	Vision	▪ **VSP.com**	
Fidelity Investments	401(k)	▪ **netbenefits.com** ▪ Fidelity NetBenefits App ▪ 800-305-4015 ▪ Monday through Friday 8:30 a.m. to Midnight ET	Manage your 401(k): ▪ Enroll or change your contributions ▪ Review/Update your 401(k) beneficiaries ▪ Participate in Virtual Education Workshops ▪ Request a rollover into the Plan (401(k) balances from prior employers) ▪ Complimentary One-on-One consultations with a Fidelity Workplace Financial Consultant
carelon behavioral health	Employee Assistance Program	▪ **achievesolutions.net/nisource** ▪ 800-946-5360 ▪ 24 hours a day, 7 days week, 365 days a year	Licensed EAP professionals provide access to: ▪ Mental Health Assistance ▪ Legal and Financial Support
NiSource	Leaves of Absence, Payroll or Vacation	▪ **Email: OneHR@nisource.com** ▪ 888-640-3320 (select from appropriate options)	Representatives are available to guide you to the right resource.
NiSource	NiSource the Benefits Source	▪ ALIGHT Mobile App ▪ 888-640-3320 ▪ 801 East 86th Avenue Merrillville, IN 46410	The Benefits Source is your single destination for assistance with your benefits. A benefits counselor will be able to assist you. GET IT ON Google Play Download on the App Store

To help you make an informed choice during Annual Enrollment, NiSource makes available Summaries of Benefits and Coverage (SBCs), each of which summarizes important information about a health coverage option in a standard format, to help you compare across options. The 2024 SBCs will be available during the Annual Enrollment period on the MySource for HR website at **mysourceforhr.com** in connection with your online enrollment in the Plans. Paper copies are also available, free of charge, by calling the Benefits Source at 888-640-3320.

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