Columbia Gas of Pennsylvania, Inc.

Standard Data Request

Revenue Requirements

Question No. RR-024:

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

Response:

The following are provided as attachments:

NiSource Welfare Benefits Program – Attachment A
NiSource Consolidated Flex Medical Plan – Attachment B
Columbia Energy Group Pension Plan – Attachment C
NiSource Pension Plan – Attachment D
NiSource Post-65 Retiree Medical Plan – Attachment E
NiSource Life & Medical Benefits Plan – Attachment F
NiSource Dental Plan – Attachment G
First Amendment to the NiSource Dental Plan – Attachment G-1
NiSource Vision Plan – Attachment H
First Amendment to the NiSource Vision Plan – Attachment H-1
NiSource Flexible Benefits Plan – Attachment I
NiSource Long-Term Disability Plan – Attachment J
NiSource Short-Term Disability Plan – Attachment K
NiSource Life Insurance Plan – Attachment L
First Amendment to the NiSource Life Insurance Plan – Attachment L-1
NiSource Retirement Savings Plan – Attachment M
NiSource Holiday Policy – Attachment N
NiSource Vacation Policy – Attachment O
NiSource Travel Accident Plan – Attachment P
First Amendment to the NiSource Travel Accident Plan – Attachment P-1
NiSource Tuition Reimbursement Plan – Attachment Q
NiSource Adoption Assistance Plan – Attachment R
First Amendment to the NiSource Adoption Assistance Plan - Attachment R-1

NISOURCE WELFARE BENEFITS PROGRAM

As Amended and Restated
Effective as of January 1, 2015

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Program 1
1.02 Program Components 1
1.03 Cafeteria Plan 1
1.04 Certain Benefit Options Not Subject to ERISA 1

ARTICLE II DEFINITIONS 1
2.01 "Claims Administrator" 1
2.02 "Code" 1
2.03 "Committee" 1
2.04 "Company" 1
2.05 "Component Welfare Plan" 2
2.06 "Concurrent Care Claim" 2
2.07 "Covered Person" 2
2.08 "Disability Benefit Claim" 2
2.09 "Employee" 2
2.10 "Employer" 2
2.11 "ERISA" 2
2.12 "Former Employee" 2
2.13 "Group Health Plan" 2
2.14 "Group Health Plan Claim" 2
2.15 "Participant" 2
2.16 "Participant Contribution" 3
2.17 "Program" 3
2.18 "Plan Administrator" 3
2.19 "Related Employer" 3
2.20 "Urgent Care Claim" 3

ARTICLE III PARTICIPATION 3
3.01 Eligibility 3
3.02 Termination of Participation 3

ARTICLE IV FUNDING AND BENEFITS 3
4.01 Funding 3
4.02 Benefits. 4

ARTICLE V ADMINISTRATION OF PROGRAM 4
5.01 Committee to Administer the Program 4
5.02 The Committee 4
5.03 Powers of the Plan Administrator 4
5.04 Interpretative Authority 5
5.05 Appointment of Claims Administrators 5
5.06 Limitation on Liability 5

ARTICLE VI CLAIMS FOR BENEFITS 5
6.01 Component Welfare Plan Claims Procedures 5
6.02 Consideration of Initial Claim 6
6.03 If the Claims Administrator Denies the Initial Claim 7
6.04 Appeal to the Claims Administrator 8

TABLE OF CONTENTS
(continued)

Page

6.05 If the Claims Administrator Denies a Claim on Appeal 9
6.06 Appeal to the Plan Administrator of Pre- and Post-Service Claim Denials. 10
6.07 If the Plan Administrator Denies a Claim on Appeal....12
6.08 Limitations Upon Civil Actions....12
6.09 Construction of Section....12

ARTICLE VII MISCELLANEOUS PROVISIONS....12
7.01 Assignment of Benefits....12
7.02 Information To Be Furnished....13
7.03 Limitation of Rights....13
7.04 Program Not Contract....13
7.05 No Limitation of Management Rights....13
7.06 Fiduciary Operation....13
7.07 No Guaranty....13
7.08 Covered Person's Responsibilities....13
7.09 Right of Recovery....14
7.10 Governing Law and Venue....14
7.11 Severability....14
7.12 Participant Litigation....14
7.13 Counterparts....14
7.14 Conflict Between Program and Component Welfare Plan....14
7.15 Notice....15
7.16 Extension of Program to Related Employers....15
7.17 Construction....15

ARTICLE VIII AMENDMENT AND TERMINATION OF THE PLAN....15
8.01 Amendment....15
8.02 Termination....15
8.03 Collective Bargaining Agreement....15

EXHIBIT A COMPONENT WELFARE PLANS....

ARTICLE I
INTRODUCTION

1.01 Purpose of Program. NiSource Inc. established the NiSource Welfare Benefits Program effective as of January 1, 2008 for the purpose of consolidating and combining into a single ERISA plan certain component welfare benefit plans maintained by the Company, and to provide Participants and their beneficiaries with the benefits described thereunder and in the Component Welfare Plans, which Component Welfare Plans were, and are hereby, incorporated into the Program as if the same were fully rewritten herein. Notwithstanding the number and types of benefits incorporated hereunder, the Program is, and shall be treated as, a single benefit plan to the extent permitted under ERISA. The Program is intended to meet all applicable requirements of ERISA, as well as rulings and regulations issued thereunder. This plan document is an amendment and restatement of the Program, effective as of January 1, 2015, that reflects certain plan design changes.

1.02 Program Components. The Program's Component Welfare Plans are described in Exhibit A attached hereto and incorporated herein by this reference, as the same may be amended or modified from time to time.

1.03 Cafeteria Plan. For purposes of Section 125 of the Code, and notwithstanding any other Component Welfare Plans that comprise the Program, the NiSource Flexible Benefits Plan is the separate written plan that is intended to meet the requirements of, and to constitute, a cafeteria plan under Section 125 of the Code and the regulations promulgated thereunder.

1.04 Certain Benefit Options Not Subject to ERISA. Notwithstanding any other provision of the Program, the Dependent Care Expense Option and the Health Savings Account Option constituting a part of the NiSource Flexible Benefits Plan are not and shall not be subject to ERISA.

ARTICLE II
DEFINITIONS

The following words and phrases as used in this Program shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

2.01 **"Claims Administrator"** means the person, persons, entity or entities appointed by the Plan Administrator to process benefit claims pursuant to Section 5.05.

2.02 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.03 **"Committee"** means the NiSource Benefits Committee.

2.04 **"Company"** means NiSource Inc., a Delaware corporation.

2.05 **"Component Welfare Plan"** means each written arrangement incorporated under this Program that is sponsored and/or maintained by the Company and that provides any employee benefit which would be treated as one or more "employee welfare benefit plans" under Section 3(1) of ERISA if offered in the absence of this Program, as such arrangement may be modified and amended from time to time. Each Component Welfare Plan under the Program is identified in Exhibit A, as updated from time to time.

2.06 **"Concurrent Care Claim"** means, with respect to benefits provided under a Group Health Plan, (a) a claim in respect of any reduction or early termination of treatment in the case of an ongoing course of treatment to be provided over a period of time or number of treatments, or (b) a request by a claimant that is an Urgent Care Claim to extend an ongoing course of treatment beyond the specified period of time or number of treatments.

2.07 **"Covered Person"** means an Employee, Former Employee or a beneficiary of an Employee or Former Employee who is covered under the Program.

2.08 **"Disability Benefit Claim"** means a claim made in respect of a benefit provided by a Component Welfare Plan, if the Component Welfare Plan conditions its availability to the claimant upon a showing or finding of disability; provided, however, that the term shall not include such a claim if the finding of disability is to be made by a party other than the Program or the Component Welfare Plan for purposes other than making a benefit determination under the Component Welfare Plan.

2.09 **"Employee"** means a regular or temporary employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.10 **"Employer"** means the Company and any Related Employer, to the extent that such Related Employer has adopted one or more of the Component Welfare Plans in accordance with the terms thereof and continues to be a Related Employer thereunder.

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

2.12 **"Former Employee"** means any person formerly employed by an Employer as an Employee or any other person treated under the terms of a Component Welfare Plan as a former employee.

2.13 **"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide (directly or otherwise) "medical care" within the meaning of Section 733(a) of ERISA to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

2.14 **"Group Health Plan Claim"** means a claim made in respect of a benefit provided under a Group Health Plan.

2.15 **"Participant"** means each Employee and Former Employee who satisfies the requirements of Article III of this Program regarding eligibility and participation.

2.16 **"Participant Contribution"** means the pre-tax or after-tax contribution required to be paid by or on behalf of a Participant, if any, as determined under each Component Welfare Plan. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-insured arrangement as well as contributions used to pay premiums under an insurance policy or other arrangement.

2.17 **"Program"** means the NiSource Welfare Benefits Program set forth herein, together with any and all amendments and supplements thereto.

2.18 **"Plan Administrator"** means the Committee.

2.19 **"Related Employer"** means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.20 **"Urgent Care Claim"** has the meaning set forth in Section 6.02(b) below.

ARTICLE III
PARTICIPATION

3.01 **Eligibility**. An Employee or Former Employee of an Employer shall become a Participant in the Program when he or she satisfies the eligibility and enrollment requirements of any Component Welfare Plan. A dependent or beneficiary of an Employee or Former Employee may become covered under the Program when he or she satisfies the eligibility and enrollment requirements of any Component Welfare Plan.

3.02 **Termination of Participation**. Participation of a Participant under the Program shall cease when such Participant ceases to participate in any Component Welfare Plan. A dependent or beneficiary of a Participant shall cease to be covered under the Program when he or she ceases to be covered under any Component Welfare Plan.

ARTICLE IV
FUNDING AND BENEFITS

4.01 **Funding**. The terms of each Component Welfare Plan shall govern the amount and timing of any Participant Contributions and any contributions required to be made by the Employer. Nothing herein requires the Employer to contribute to or under any Component Welfare Plan, or to maintain any fund or segregate any amount for the benefit of any Participant or his beneficiary, except to the extent specifically required under the terms of a Component Welfare Plan. No Participant or beneficiary shall have any right to, or interest in, the assets of any Employer.

Different funding mechanisms may be used to provide benefits under any Component Welfare Plan. Such funding mechanisms shall be set out in the policies, contracts or other documents that form part of such Component Welfare Plan.

4.02 Benefits. Benefits will be paid solely in the form and in the amount set forth under the Component Welfare Plans.

ARTICLE V
ADMINISTRATION OF PROGRAM

5.01 Committee to Administer the Program. The Program shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Program to the extent permitted by ERISA.

5.02 The Committee. The powers of the Committee are set forth below and in the charter that created the Committee, as such charter may be modified from time to time.

5.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Program properly, including, but not limited to, the following:

(a) To maintain all Program records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Program, construe Program terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Program;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Program;

(h) To determine the status and rights of all Covered Persons;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Program or any Component Welfare Plan;

(k) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Program;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Program properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the

administration of the Program. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Program.

Notwithstanding the foregoing or any other provision of this Program, to the extent the benefits under any Component Welfare Plan are provided under a fully insured arrangement, the insurance company for such Component Welfare Plan shall have the responsibility for determining entitlement to benefits thereunder and for prescribing the claims procedures to be followed by Participants and beneficiaries thereunder. The insurance company will act as a named fiduciary with respect to such Component Welfare Plan and this Program and will have the full power to interpret and apply the terms of such Component Welfare Plan as they relate to benefits provided under the applicable insurance policy.

5.04 Interpretative Authority. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Program or the interpretation thereof, including, without limitation, the construction of the language of the Program (and of the Component Welfare Plans) and any summary plan descriptions thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Program shall be binding upon all persons dealing with the Program or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Program shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

5.05 Appointment of Claims Administrators. The Plan Administrator shall appoint one or more Claims Administrators to provide administrative services to the Plan Administrator in connection with the operation of the Program and the Component Welfare Plans and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons, entity or entities serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

5.06 Limitation on Liability. Notwithstanding any of the other provisions of the Program, none of the Company, any Employer, any member of the Committee or any Employee or agent of any Employer, shall be liable to any Participant or any other person for any claim, loss, liability or expense incurred in connection with the Program or the Component Welfare Plans.

ARTICLE VI
CLAIMS FOR BENEFITS

6.01 Component Welfare Plan Claims Procedures. Except as otherwise provided in this Section 6.01, a claim for benefits under a Component Welfare Plan shall be submitted to the party designated under, and shall be governed solely by, the claims procedures prescribed under the terms of such Component Welfare Plan and not the claims procedures of this Article VI. In the event, and only in the event, that (i) a Component Welfare Plan does not prescribe claims procedures for benefits that satisfy the requirements of Section 503 of ERISA, or (ii) the Plan

Administrator determines that the claims procedures described in a particular Component Welfare Plan shall not apply, the claims procedures described below in this Article VI shall apply with respect to such Component Welfare Plan. Notwithstanding the previous sentence, the claims procedures of this Article VI shall not apply with respect to a Component Welfare Plan that is subject to Code Section 9815 or ERISA Section 715.

6.02 Consideration of Initial Claim.

(a) Filing Initial Claim. The Claims Administrator shall process benefit claims pursuant to the procedures set forth below. Except as otherwise provided in a Component Welfare Plan, initial claims shall be filed within three years from the date a charge is incurred.

(b) Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Program. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within 24 hours after receipt of the claim he or she shall be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Claims Administrator shall notify the claimant of its decision regarding the completed claim either within 48 hours of receipt of the missing information, or within 48 hours of the end of the reasonable time period indicated in the notice.

An "Urgent Care Claim" is any Group Health Plan 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 the ability of the patient to regain maximum function, or in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Program. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the initial 15-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within five days after receipt of the claim he or she shall be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Pre-Service Claim" is any Group Health Plan Claim where the Component Welfare Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide notice of an adverse determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Program if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. With respect to a Group Health Plan Claim, if the claimant does not provide sufficient information for the Claims Administrator to make a determination, the claimant shall receive notice of the specific information necessary to complete the claim. Once the claimant is notified he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Post-Service Claim" is any claim that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

Notwithstanding the foregoing, for Post-Service Claims that are not Group Health Plan Claims or Disability Benefit Claims, a 90-day determination period and a 90-day extension period shall be substituted for the 30-day determination period and 15-day extension period set forth above in this subsection (d).

Notwithstanding the foregoing, for Post-Service Claims that are Disability Benefit Claims, a 45-day determination period and a 30-day extension period shall be substituted for the 30-day determination period and the 15-day extension period set forth above in this subsection (d). In addition, the determination period may be extended for up to an additional 30 days for matters beyond the control of the Program if, prior to the expiration of the initial 30-day extension period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. Any notice of extension with respect to a Disability Benefits Claim 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 the claimant shall be afforded at least 45 days within which to provide the specified information.

(e) Concurrent Care Claims. In the case of an ongoing course of treatment covered under a Group Health Plan, the claimant shall receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Claims Administrator shall notify the claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. The Claims Administrator shall be solely responsible for handling all Concurrent Care Claims.

6.03 If the Claims Administrator Denies the Initial Claim. If the Claims Administrator denies all or any portion of a claim, it shall provide notice of the denial stating (1) the specific reason for the denial; (2) the specific Component Welfare Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) a description

of the Component Welfare Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 Component Welfare Plan to the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Claims Administrator denies a claimant's Urgent Care Claim in whole or in part, the Claims Administrator shall provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Claims Administrator shall provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

6.04 Appeal to the Claims Administrator.

(a) General. If the Claims Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for review to the Claims Administrator within 180 days of receipt of the Claims Administrator's notice of claim denial. Notwithstanding the foregoing, for claims other than Group Health Claims and Disability Benefit Claims, a written request for review of the denial of all or any portion of such claim must be sent to the Claims Administrator within 60 days of receipt of the Claims Administrator's notice of claim denial.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a request for review, the Claims Administrator shall conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a Group Health Plan Claim or a Disability Benefit Claim, the review shall not afford any deference to the Claims Administrator's adverse benefit determination, and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is subject of the appeal, nor the subordinate of such individual.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, if the denial 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 consultant 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 the claimant the identities of any medical or vocational experts whose advice was obtained on behalf of the Component Welfare Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Expedited Review for Urgent Care Claims. In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. The Claims Administrator shall notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(d) Post-Service Claims. In the case of a Group Health Plan Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

In the case of a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review, except that such 45-day period may be extended for up to 45 days for special circumstances if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

In the case of a claim other than a Group Health Plan Claim or a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review, except that such 60-day period may be extended for up to 60 days for special circumstances if, prior to the expiration of the initial 60-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

6.05 If the Claims Administrator Denies a Claim on Appeal. If the Claims Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Component Welfare Plan provisions on which the denial is based; (3) a

statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Component Welfare Plan and a claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 Component Welfare Plan to the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and your State insurance regulatory agency."

6.06 Appeal to the Plan Administrator of Pre- and Post-Service Claim Denials.

(a) General. If the Claims Administrator denies all or any portion of a Pre-Service Claim or a Post-Service Claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of receipt of the Claims Administrator's notice of claim denial. Notwithstanding the foregoing, for claims other than Group Health Claims and Disability Benefit Claims, a written request for review of the denial of all or any portion of such claim on appeal must be sent to the Claims Administrator within 60 days of receipt of the Claims Administrator's notice of claim denial.

Requests for review should be sent to:

NiSource Inc.
801 E. 86th Avenue
Merrillville, Indiana 46410
Attn: ERISA Claims Review
Benefits Administration Department

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include any denial letter he or she received and

any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a request for review, the Plan Administrator shall conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a Disability Benefits Claims or a Group Health Plan Claim, the review shall not afford any deference to the Plan Administrator's adverse benefit determination, and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is subject of the appeal, nor the subordinate of such individual.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, if the denial was based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant 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 Plan Administrator shall provide to the claimant the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Pre-Service Claims. In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant 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 a claimant's request for review.

(c) Post-Service Claims. In the case of a Group Health Plan Claim, the Plan Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

In the case of a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review, except that such 45-day period may be extended for up to 45 days for special circumstances if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

In the case of a claim other than a Group Health Plan Claim or a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review, except that such 60-day period may be extended for up to 60 days for special circumstances if, prior to the expiration of the initial 60-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

6.07 If the Plan Administrator Denies a Claim on Appeal. If the Plan Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Component Welfare Plan and a claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, if the Plan 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant upon request. If the Plan 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 Component Welfare Plan to the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and your State insurance regulatory agency."

6.08 Limitations Upon Civil Actions. With respect to a claim for benefits under the Program subject to this Article VI, no civil action may be commenced unless the claims procedure process described in this Article VI has been exhausted. In addition, in no event may any civil action regarding such 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.

6.09 Construction of Section. This Article shall be construed in a manner consistent with Department of Labor regulations governing claims procedures applicable to "employee welfare benefit plans" within the meaning of Section 3(1) of ERISA.

ARTICLE VII
MISCELLANEOUS PROVISIONS

7.01 Assignment of Benefits. Except as required by law, or as expressly provided in a Component Welfare Plan, no benefit payable at any time under the Program shall be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, bankruptcy, or, in any other manner, and no benefit payable under the Program shall be liable for, or subject to, any obligation or liability of any Covered Person. If any Covered Person entitled to a benefit under any Component Welfare Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part, or if by reason of his or her bankruptcy or other

event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her beneficiaries, in a manner the Plan Administrator may deem proper.

7.02 Information To Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Program.

7.03 Limitation of Rights. Neither the establishment of the Program nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

7.04 Program Not Contract. The Program shall not be deemed to constitute a contract between an Employer and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Program shall be deemed to give any Employee the right to be retained in the service of an Employer or to interfere with the right of an Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by an Employer with the bargaining representative of any Employee.

7.05 No Limitation of Management Rights. Participation in the Program shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect an Employer's rights to discipline or terminate an Employee.

7.06 Fiduciary Operation. Each fiduciary with respect to the Program shall discharge his or her duties with respect to the Program solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Program; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Program, except as otherwise required by law.

7.07 No Guaranty. No person shall have any right or interest in the Program other than as specifically provided herein. Except to the extent required by law, no Employer shall be liable for the payment of any benefit provided for herein. All benefits hereunder shall be payable only from the Program, and only to the extent that the Program has been allocated sufficient assets; provided, however, that benefits provided under a Component Welfare Plan that are furnished pursuant to a policy or contract of insurance with an insurance company shall be paid solely by such insurance company.

7.08 Covered Person's Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor a Claims Administrator shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Program and it cannot be made because (1) the current address is incorrect; (2) the Covered Person does not respond to the notice sent to the current address; (3) there are conflicting claims to such payment;

or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Program, without interest.

7.09 Right of Recovery. Whenever the Program, for whatever reason, has overpaid the amount of benefits that should have been provided, the Program shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Program shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization.

7.10 Governing Law and Venue. The Program shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Program by establishing a uniform application of law with respect to the administration of the Program, the provisions of this Section 7.10 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Program shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Program and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

7.11 Severability. In the event any portion of this Program is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Program, and the balance of the Program shall remain in full force and effect.

7.12 Participant Litigation. In any action or proceeding involving the Program, Covered Persons or any other person having or claiming to have an interest in the Program shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Program. To the extent permitted by law, if a legal action is begun against the Company, an Employer or other organization or institution providing benefits under the Program by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company, the Employer or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Program shall constitute a release of the Company, each Employer and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

7.13 Counterparts. This Program document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

7.14 Conflict Between Program and Component Welfare Plan. In the event that the provisions of any Component Welfare Plan conflict with the provisions of this document or any other Component Welfare Plan, the Plan Administrator shall, in its discretion, interpret the terms and purpose of the Program so as to resolve any conflict. However, the terms of this document may

not increase the rights of a Participant or his beneficiary to benefits available under any Component Welfare Plan.

7.15 **Notice**. Any notice given under this Program shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to a Claims Administrator, when addressed to it at its home office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Claims Administrator.

7.16 **Extension of Program to Related Employers**. Any Related Employer may adopt one or more of the Component Welfare Plans in accordance with the terms thereof and thereby qualify its Employees and Former Employees to become Participants thereunder and under this Program. A Related Employer that adopts one or more Component Welfare Plans agrees that the Committee shall have the sole right to amend or terminate this Program and that the Committee shall act as the agent for such Related Employer for all purposes of administration of the Program. A Related Employer shall cease to be an Employer under this Program when it is no longer an "Employer" under the terms of any Component Welfare Plan or when all Component Welfare Plans have otherwise terminated with respect to such Related Employer.

7.17 **Construction**. The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Program, nor in any way shall affect the Program or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

ARTICLE VIII
AMENDMENT AND TERMINATION OF THE PLAN

8.01 **Amendment**. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Program. Unless expressly provided otherwise, no amendment shall affect, or be construed to affect, any existing delegations to amend the Program. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of plan assets of the Program to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration.

8.02 **Termination**. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Program for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Program and the Committee may terminate the Program in whole or in part at any time , in each case without liability for such discontinuance or termination.

8.03 **Collective Bargaining Agreement.** Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Program shall be subject to the express terms of any applicable collective bargaining agreement.

[The remainder of this page is intentionally left blank.]

IN WITNESS WHEREOF, the Committee has caused this Program to be executed on its behalf, by one of its members duly authorized, this 22nd day of JUNE, 2015, to be effective as of January 1, 2015.

NISOURCE BENEFITS COMMITTEE

By: _____

Its: _____
COMMITTEE MEMBER

EXHIBIT A
COMPONENT WELFARE PLANS

NiSource Dental Plan

NiSource Flexible Benefits Plan

NiSource Inc. Bargaining Unit Employees Vision Plan

NiSource Inc. Executive Severance Policy

NiSource Inc. Severance Policy

NiSource Long-Term Disability Plan

NiSource Short-Term Disability Plan

NiSource Travel Accident Plan

NiSource Vision Plan

Northern Indiana Public Service Company Employee Life Insurance Plan

NISOURCE CONSOLIDATED
FLEX MEDICAL PLAN

As Amended and Restated
Effective as of January 1, 2016

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Plan 1
1.02 Plan Components 1

ARTICLE II DEFINITIONS 1
2.01 "Additional Preventive Health Services" 1
2.02 "Adopted Child" 1
2.03 "Affordable Care Act" 1
2.04 "Annual Enrollment Period" 1
2.05 "Available Pre-65 Retiree Coverage Option" 1
2.06 "Category of Coverage" 1
2.07 "Child" 1
2.08 "Claims Administrator" 2
2.09 "COBRA" 2
2.10 "COBRA Continuation Coverage" 2
2.11 "Code" 2
2.12 "Columbia Divested Company" 2
2.13 "Committee" 2
2.14 "Company" 2
2.15 "Co-Insurance" 2
2.16 "Co-Payment" 2
2.17 "Coverage Option" 2
2.18 "Covered Employee" 2
2.19 "Covered Expense" 2
2.20 "Covered Retiree Group" 2
2.21 "Covered Participant" 2
2.22 "Covered Percentage" 3
2.23 "Covered Person" 3
2.24 "Covered Person Contribution" 3
2.25 "Covered Same-Sex Domestic Partner" 3
2.26 "Covered Service" 3
2.27 "CPG" 3
2.28 "CPG Related Employer" 3
2.29 "CPG Spin-Off" 3
2.30 "Deductible" 3
2.31 "Defined Dollar Subsidy" 3
2.32 "Dependent" 3
2.33 "Employee" 4
2.34 "Employer" 4
2.35 "ERISA" 5
2.36 "Exempt Employee" 5
2.37 "Experimental or Investigational" 5
2.38 "Family" 5
2.39 "Financially Interdependent" 5
2.40 "Flexible Benefits Plan" 6
2.41 "FMLA" 6
2.42 "Foster Child" 6

2.43 "Full-Time Employee" 6
2.44 "Group Health Plan" 6
2.45 "HD PPO 1" 6
2.46 "HD PPO 2" 6
2.47 "HD PPO Option" 6
2.48 "HIPAA" 6
2.49 "HMO Option" 6
2.50 "Home Health Care Agency" 6
2.51 "Hospital" 6
2.52 "Injury" 6
2.53 "IRO" 7
2.54 "Legal Ward" 7
2.55 "Maximum Allowed Amount" 7
2.56 "Medicaid" 7
2.57 "Medically Necessary" 7
2.58 "Medicare" 7
2.59 "Newborn Child" 7
2.60 "NIPSCO" 7
2.61 "NIPSCO Represented Retiree" 7
2.62 "No Coverage Option" 7
2.63 "Non-Exempt Employee" 7
2.64 "Non-Represented" 7
2.65 "Other Insured Arrangement Option" 7
2.66 "Other Party" 7
2.67 "Out-of-Pocket Expense Limitation" 8
2.68 "Part-Time Employee" 8
2.69 "Participant" 8
2.70 "Physician" 8
2.71 "Plan" 8
2.72 "Plan Administrator" 8
2.73 "Plan Year" 8
2.74 "Post-65 Retiree" 8
2.75 "Post-65 Retiree Medical Plan" 8
2.76 "Post-65 Retiree Plan Participant" 8
2.77 "PPO Option" 8
2.78 "Pre-65 Retiree" 8
2.79 "Pre-Certification Provider" 8
2.80 "Pregnancy" 9
2.81 "Preventive Health Services" 9
2.82 "Provider" 9
2.83 "Qualified Beneficiary" 9
2.84 "Qualifying Event" 9
2.85 "Recommended Preventive Health Services" 10
2.86 "Related Employer" 10
2.87 "Relative" 10
2.88 "Represented" 10
2.89 "Retiree" 10
2.90 "Room and Board Charges" 11
2.91 "Same-Sex Domestic Partner" 11
2.92 "Semi-Private Rate" 12
2.93 "Separation Date" 12

2.94 "Sickness" 12
2.95 "Special Enrollment Period" 12
2.96 "Spouse" 12
2.97 "Status Change" 12
2.98 "Stepchild" 13
2.99 "Summary Plan Description" 13
2.100 "Surgical Procedure" 13
2.101 "Urgent Hospitalization" 13
2.102 "Well Newborn Child" 13

ARTICLE III PARTICIPATION 13
3.01 Eligibility 13
3.02 Enrollment 14
3.03 Categories of Coverage 18
3.04 Opt-Out Credit 19
3.05 Election of a Coverage Option 19
3.06 Election of a Category of Coverage 20

ARTICLE IV RETIREE COVERAGE 20
4.01 Participation in Coverage Options 20
4.02 Special Provisions Applicable to 2002 NiSource Organization Restructuring 22
4.03 Special Provisions Applicable to Certain Outsourced and Severed Employees 23
4.04 Special Provisions Applicable to Pre-65 Retirees and Post-65 Retiree Plan Participants Who are Former Represented Employees 24

ARTICLE V RESERVED 24

ARTICLE VI HD PPO OPTIONS 24
6.01 Eligibility 24
6.02 Participating Providers 24
6.03 HD PPO Options 24
6.04 Health Savings Accounts 25

ARTICLE VII PPO OPTION 26
7.01 Eligibility 26
7.02 Participating Providers 26
7.03 PPO Option 26
7.04 Special NIPSCO Union Provisions 27

ARTICLE VIII HMO OPTION 28

ARTICLE IX OTHER INSURED ARRANGEMENT OPTION 28

ARTICLE X PARTICIPANT PAYMENTS AND LIMITS 28
10.01 Deductible 28
10.02 Co-Insurance 29
10.03 Co-Payments 29
10.04 Out-of-Pocket Expense Limitation 29
10.05 Schedule of Co-Payments and Deductibles 30
10.06 Special Co-Insurance Provisions 31
10.07 Maximum Allowed Amount 32

ARTICLE XI CONTRIBUTIONS TO THE PLAN 35
11.01 Employer Contributions 35
11.02 Covered Person Contributions 35

ARTICLE XII MANDATORY COST CONTAINMENT PROGRAM 35
12.01 Pre-Admission Pre-Certification 35
12.02 Pre-Certification Procedure 35
12.03 Urgent Hospital Admission 35
12.04 Continued Stay Review 36
12.05 Other Required Pre-Certifications 36
12.06 Penalty for Non-Compliance 36

ARTICLE XIII MEDICAL BENEFITS 36
13.01 General 36
13.02 Preventive Care Benefit 36
13.03 Well Child Care 37
13.04 Maternity Benefits 37
13.05 Convalescent Care Benefit 37
13.06 Home Health Care 38
13.07 Hospice Care Benefit 39
13.08 Elective Sterilization 40
13.09 Newborn Hospital Expenses 41
13.10 Human Organ and Tissue Transplant Benefit. 41
13.11 Miscellaneous Covered Expenses 42
13.12 Alternate Treatment Under Case Management 46
13.13 Payment of Benefits 46
13.14 Designation of Beneficiaries 46
13.15 Facility of Payment 46

ARTICLE XIV PRESCRIPTION DRUG COVERAGE 46
14.01 General 46
14.02 Deductible 47
14.03 Co-Payments and Co-Insurance 47
14.04 Definitions 48
14.05 Items Covered 48
14.06 Items Not Covered 49
14.07 Preauthorization 49
14.08 Step-Therapy 49
14.09 Brand versus Generic Drugs 50

ARTICLE XV MENTAL ILLNESS COVERAGE 50
15.01 General 50
15.02 Coverage 50

ARTICLE XVI EMPLOYEE ASSISTANCE PROGRAM COVERAGE 52
16.01 Benefits 52
16.02 Claim for Benefits 52

ARTICLE XVII GENERAL EXCLUSIONS 52
17.01 Services or Supplies not Covered under PPO Option 52
17.02 Services, Supplies and Charges not Covered under HD PPO Options 55

ARTICLE XVIII SUBROGATION 60
18.01 Subrogation 60
18.02 Right of Recovery 60
18.03 Application to Funds Recovered 60
18.04 Cooperation Required 60
18.05 First Lien Created 61
18.06 Constructive Trust 61
18.07 Personal Liability Created 61

ARTICLE XIX NONDUPLICATION OF BENEFITS 61
19.01 General 61
19.02 Definitions 61
19.03 Application of the Rules 62
19.04 Plan As Primary Payor 63
19.05 Plan As Secondary Payor 63
19.06 When Other Plan Has No Nonduplication of Benefits Rules 63
19.07 Vehicle Coverage Limitation 63
19.08 If Medicare Is Involved 63

ARTICLE XX ADMINISTRATION OF PLAN 65
20.01 Committee to Administer the Plan 65
20.02 The Committee 65
20.03 Powers of the Plan Administrator 66
20.04 Interpretative Authority 66
20.05 Appointment of the Claims Administrator 67

ARTICLE XXI CLAIMS FOR BENEFITS 67
21.01 Consideration of Initial Claim 67
21.02 If the Claims Administrator Makes an Adverse Benefit Determination Regarding the Initial Claim 68
21.03 Mandatory First-Level Internal Appeal to the Claims Administrator. 69
21.04 If the Claims Administrator Makes an Adverse Benefit Determination on a Mandatory First-Level Internal Appeal 71
21.05 Voluntary Second-Level Internal Appeal to the Claims Administrator of Pre- and Post-Service Claim Denials. 71
21.06 If the Claims Administrator Makes an Adverse Benefit Determination on a Voluntary Second-Level Internal Appeal 73
21.07 Full and Fair Review 73
21.08 Voluntary External Review by Independent Review Organization 73
21.09 Limitations Upon Civil Actions 77
21.10 Construction of Article 77

ARTICLE XXII TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE 78
22.01 Cessation of Participation 78
22.02 Leave of Absence Under the FMLA 81
22.03 Military Leave Policy 81
22.04 Severance 81
22.05 COBRA 81

ARTICLE XXIII PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION 84
23.01 General 84

23.02 Permitted Uses and Disclosure 84
23.03 Disclosures to Company 84
23.04 Adequate Separation 85
23.05 Unauthorized Use or Disclosure 86
23.06 Special Amendatory Authority 86

ARTICLE XXIV PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION 86
24.01 General 86
24.02 Duty of the Plan Sponsor 86

ARTICLE XXV MISCELLANEOUS PROVISIONS 86
25.01 Assignment of Benefits 86
25.02 Information To Be Furnished 87
25.03 Limitation of Rights 87
25.04 Plan Not Contract 87
25.05 Fiduciary Operation 87
25.06 No Guaranty 88
25.07 Misrepresentation 88
25.08 Inadvertent Error 88
25.09 No Limitation of Management Rights 88
25.10 No Liability for Acts of Any Provider 88
25.11 Covered Person's Responsibilities 88
25.12 Right of Recovery 88
25.13 Governing Law and Venue 89
25.14 Severability 89
25.15 Participant Litigation 89
25.16 Counterparts 89
25.17 Notice 89
25.18 Extension of Plan to Related Employers. 89

ARTICLE XXVI FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 90
26.01 Plan Self-Insured 90
26.02 Participants' and Dependents' Rights Unsecured 90
26.03 Amendment 90
26.04 Termination 90
26.05 Collective Bargaining Agreement 90

SCHEDULE 1 PRE-65 RETIREE BENEFIT PROGRAM MATRIX .....

ARTICLE I
INTRODUCTION

1.01 **Purpose of Plan.** Columbia Energy Group established and maintained the Columbia Energy Group Medical Plan to provide group medical benefits for the participants and beneficiaries thereunder. The Columbia Energy Group Medical Plan was broadened to include coverage for the former participants and beneficiaries of other medical plans sponsored by NiSource Inc. (the "Company") or an affiliate, was renamed the NiSource Consolidated Flex Medical Plan, effective as of January 1, 2004, and as of such date, was sponsored and maintained by the Company. The Plan was further amended and restated, effective as of January 1, 2006, January 1, 2008, January 1, 2010, January 1, 2011, January 1, 2013, January 1, 2014, January 1, 2015 and July 1, 2015. This is an amended and restated version of the Plan, effective as of January 1, 2016, that reflects certain statutory, regulatory and plan design changes.

1.02 **Plan Components.** The Plan has 5 components: HD PPO 1, HD PPO 2, PPO, HMO, and Other Insured Arrangements. Alternatively, an Employee may choose the No Coverage Option.

ARTICLE II
DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

2.01 **"Additional Preventive Health Services"** means those items or services constituting preventive care or screening that are described herein or in a Summary Plan Description as being covered by the Plan, but which do not constitute Recommended Preventive Health Services.

2.02 **"Adopted Child"** means any child legally adopted by, or placed for adoption with, a Covered Participant or Covered Same-Sex Domestic Partner.

2.03 **"Affordable Care Act"** means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended.

2.04 **"Annual Enrollment Period"** means the period selected by the Company each year during which time an Employee or Retiree may select a Coverage Option to be effective for the following Plan Year.

2.05 **"Available Pre-65 Retiree Coverage Option"** means, with respect to a Pre-65 Retiree, a Pre-65 Retiree's Dependent, or a Dependent of a Post-65 Retiree Plan Participant, any Coverage Option that is available to the Retiree's Covered Retiree Group, as indicated in Schedule 1 attached hereto.

2.06 **"Category of Coverage"** means each of the coverage choices described in Section 3.03.

2.07 **"Child"** means a person who is either (1) a naturally born child of a Covered Participant; (2) an Adopted Child; (3) a Stepchild; (4) a Foster Child; (5) a Legal Ward who is dependent upon a Covered Participant or Covered Same-Sex Domestic Partner for at least 50% of his or her financial support and who may be claimed on the income tax return of the Covered Participant or

Covered Same-Sex Domestic Partner as a dependent (without giving effect to the Legal Ward's gross income); or (6) any person deemed by court order to be a Child for purposes of the Plan.

2.08 **"Claims Administrator"** means the person, persons or entity appointed by the Plan Administrator to process benefit claims pursuant to Section 20.05.

2.09 **"COBRA"** means Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.10 **"COBRA Continuation Coverage"** means continuation coverage to the extent required by COBRA.

2.11 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.12 **"Columbia Divested Company"** means any one of the following companies that previously was affiliated with a Related Employer: Columbia Energy Services Corp., Columbia Propane Corporation, Columbia Electric Corporation, Columbia LNG Corporation, Energy.com Corporation, Columbia Trans Communications, Commonwealth Propane, Columbia Propane LP, Columbia Petroleum Corporation, Columbia Natural Resources Inc., Hawg Hauling & Disposal Inc., Coal Gas, CS-42, Gas Development, New York Gas & Elec, Pittsburgh Market Division and Columbia Gas of West Virginia.

2.13 **"Committee"** means the NiSource Benefits Committee or its predecessor, the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

2.14 **"Company"** means NiSource Inc., a Delaware corporation.

2.15 **"Co-Insurance"** means the percentage of a Covered Expense that remains the responsibility of a Covered Person, and does not include any Co-Payment.

2.16 **"Co-Payment"** means a flat dollar amount that a Covered Person must pay before an expense will be covered.

2.17 **"Coverage Option"** means an HD PPO Option, a PPO Option, an HMO Option, an Other Insured Arrangement Option or a No Coverage Option; provided, however, the availability of an HMO Option or an Other Insured Arrangement Option may be subject to certain geographic restrictions based upon the residence of the Covered Person and such Option may impose eligibility restrictions in addition to those set forth herein, all as more particularly set forth in the applicable certificates of coverage, group insurance policies and other applicable governing documents with respect to such Option.

2.18 **"Covered Employee"** means an individual who is (or was) provided coverage under the Plan by virtue of the performance of services by the individual for an Employer.

2.19 **"Covered Expense"** means a service, treatment or supply, the Covered Percentage of which is paid for by the Plan, or which is subject to the applicable Deductible and Co-Insurance.

2.20 **"Covered Retiree Group"** means a group of retirees described in Schedule 1 attached hereto in which a Retiree is a member, as determined by the Plan Administrator or its designee, in its sole discretion.

2.21 **"Covered Participant"** means a Participant or Post-65 Retiree Plan Participant.

2.22 **"Covered Percentage"** means the percentage of a Covered Expense covered by the Plan.

2.23 **"Covered Person"** means an Employee, Retiree or Dependent covered under the Plan, and includes a Qualified Beneficiary covered under the Plan.

2.24 **"Covered Person Contribution"** means the contribution required under Section 11.01.

2.25 **"Covered Same-Sex Domestic Partner"** means a Same-Sex Domestic Partner covered under the Plan.

2.26 **"Covered Service"** has the same meaning as "Covered Expense."

2.27 **"CPG"** means Columbia Pipeline Group, Inc., a Delaware corporation.

2.28 **"CPG Related Employer"** means, on and after the Separation Date, (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes CPG; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with CPG; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes CPG.

2.29 **"CPG Spin-Off"** means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG.

2.30 **"Deductible"** has the meaning set forth in Section 10.01.

2.31 **"Defined Dollar Subsidy"** means the Company's contribution toward the cost of coverage for certain Retirees, as described in Sections 4.01 and 4.02.

2.32 **"Dependent"** means:

(a) The Spouse of a Covered Participant, if not legally separated, and, with respect to the Spouse of a Retiree, who has not attained age 65;

(b) With respect to coverage under an HMO Option or an Other Insured Arrangement Option, but only to the extent and for as long as required by applicable state law, a former Spouse of a Covered Participant or a Spouse from whom a Covered Participant is legally separated;

(c) The Same-Sex Domestic Partner of a Covered Participant, provided that the term "Dependent' shall not include (i) a Retiree's Same-Sex Domestic Partner who has attained age 65, or (ii) the Same-Sex Domestic Partner of a Retiree who retired on or before February 1, 2013;

(d) A person who satisfies the provisions of Section 22.01(c) of the Plan for continued coverage as a surviving dependent, subject to any other limitations on dependent status (e.g., the limiting age for eligibility of a Child) included in this Section 2.32;

(e) A Child who has not attained 26 years of age;

(f) An unmarried Child who satisfies the "dependency test" described in this Section 2.32 and who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the Child's disability, if requested by the Claims Administrator, is

received by the Claims Administrator within 31 days of the date Dependent status would otherwise terminate and is provided to the Claims Administrator every three years thereafter, or more frequently if requested by the Claims Administrator; (2) the Child is dependent upon the Employee or Retiree (or Covered Same-Sex Domestic Partner of the Employee or Retiree, as the case may be) for financial support and maintenance; (3) the Employee or Retiree continues to be covered by the Plan or by the Post-65 Retiree Medical Plan; (4) the Child's disability continues; and (5) the Child has not attained age 65; or

(g) A Child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient under ERISA, as having a right to participate in the Plan as a Dependent.

For purposes of this Section 2.32, a Child of a Covered Participant or of a Covered Same-Sex Domestic Partner satisfies the "dependency test" for a particular Plan Year if

(x) the Covered Participant or the Covered Same-Sex Domestic Partner would be allowed a dependent exemption for such Child in computing his or her federal taxable income for such Plan Year, or

(y) each of the following conditions is satisfied: (1) such Child receives over half of his or her support during the Plan Year from his or her parents and is in the custody of one or both parents for more than half of the Plan 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 Plan 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 month of the Plan Year.

For purposes of the "dependency test" in clause (x) above, the Child's gross income for such Plan Year may be ignored in determining whether the Covered Participant or Covered Same-Sex Domestic Partner would be entitled to a dependent exemption for such Child for such Plan Year.

Notwithstanding any other provision of the Plan, but subject to (i) the provisions of Section 22.01(c) regarding coverage for a surviving dependent, providing the surviving dependent was entitled to such coverage immediately prior to January 1, 2017, and (ii) the provisions of Section 22.05(h), regarding COBRA-like continuation coverage for a Covered Person under the circumstances described therein, provided the Covered Person was entitled to such coverage immediately prior to January 1, 2017, effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child shall be a Dependent eligible for coverage, or entitled to any benefits, under the Plan.

2.33 **"Employee"** means a regular or temporary employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.34 **"Employer"** means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that a group health plan providing medical benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer

to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.34, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

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

2.36 **"Exempt Employee"** means an Employee who is not entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. § 201, et seq.

2.37 **"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.

2.38 **"Family"** means a Participant and such Participant's covered Dependents, or the covered Dependents of a Post-65 Retiree Plan Participant.

2.39 **"Financially Interdependent"** means that a Covered Participant and another person satisfy any two of the following conditions:

(a) the Covered Participant designates such other person as the Covered Participant's beneficiary for employer-sponsored retirement or life insurance benefits;

(b) the Covered Participant designates such other person as the primary beneficiary under the Covered Participant's will;

(c) the Covered Participant designates such other person as the Covered Participant's attorney-in-fact under a durable power of attorney for health care;

(d) the Covered Participant and such other person have a common ownership or leasehold interest in real property;

(e) the Covered Participant and such other person have joint bank or credit accounts or joint investments; or

(f) the Covered Participant and such other person have joint liability for a mortgage, lease or loan.

2.40 **"Flexible Benefits Plan"** means the NiSource Flexible Benefits Plan, as amended or restated from time to time.

2.41 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

2.42 **"Foster Child"** means a child legally placed in the custody of a Covered Participant or Covered Same-Sex Domestic Partner by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, who is receiving parental care from such Covered Participant Covered Same-Sex Domestic Partner, and for whom such Covered Participant or Covered Same-Sex Domestic Partner is legally responsible to provide medical care.

2.43 **"Full-Time Employee"** means an Employee characterized by an Employer as a full-time employee who regularly works 40 or more hours per week or, with respect to a Represented Employee, who regularly works such other period of time that is specified in the collective bargaining agreement covering such Employee as constituting full-time status for purposes of the Plan.

2.44 **"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

2.45 **"HD PPO 1"** means the HD PPO 1 Option described in Article VI.

2.46 **"HD PPO 2"** means the HD PPO 2 Option described in Article VI.

2.47 **"HD PPO Option"** means one of the high deductible (HD) PPO Coverage Options described in Article VI.

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

2.49 **"HMO Option"** means a Coverage Option offered through a health maintenance organization pursuant to Article VIII.

2.50 **"Home Health Care Agency"** means a public or private agency or organization that specializes in providing medical care and treatment in the home.

2.51 **"Hospital"** means an institution that, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians who are duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses. It is not, other than incidentally, a nursing home, or a place for rest or for the aged.

2.52 **"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 a Covered Person's body from an external force or contact.

2.53 **"IRO"** means an accredited independent review organization.

2.54 **"Legal Ward"** means any Child for whom a Covered Participant or Covered Same-Sex Domestic Partner is legal guardian, provided that such Child is dependent on such Covered Participant or Covered Same-Sex Domestic Partner for principal support and maintenance.

2.55 **"Maximum Allowed Amount"** means the maximum amount of charges that the Plan will pay for a service, treatment or supply. The determination of the Maximum Allowed Amount shall be made by the Claims Administrator or Plan Administrator in its sole discretion based on criteria agreed upon by the Company and the Claims Administrator or Plan Administrator, as applicable, including without limitation the criteria set forth in Section 10.07 below.

2.56 **"Medicaid"** means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

2.57 **"Medically Necessary"** means a service or supply ordered or prescribed by a Physician 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 the Covered Person's health status to result in information that could affect treatment, if a diagnostic procedure; and (3) no more costly than any alternative.

2.58 **"Medicare"** means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended.

2.59 **"Newborn Child"** means any Child newly born to a Covered Participant and his or her Spouse.

2.60 **"NIPSCO"** means Northern Indiana Public Service Company.

2.61 **"NIPSCO Represented Retiree"** means a Retiree who is a former NIPSCO Represented Employee.

2.62 **"No Coverage Option"** means an Employee's or a Pre-65 Retiree's election, or a Post-65 Retiree Plan Participant's election (on behalf of his or her Dependent), not to become covered under a Coverage Option.

2.63 **"Non-Exempt Employee"** means an employee who is entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. § 201 et seq.

2.64 **"Non-Represented"** means a Full-Time or Part-Time Employee or Retiree who is not covered by a collective bargaining agreement between an Employer and a union.

2.65 **"Other Insured Arrangement Option"** means any other fully-insured arrangement maintained by the Company.

2.66 **"Other Party"** includes, without limitation, any of the following:

(a) Any party or parties who cause a Sickness or Injury;

(b) Any insurer or other indemnifier of the party or parties who caused a Sickness or Injury;

(c) Any guarantor of the party or parties who cause a Sickness or Injury;

(d) A Covered Person's insurer;

(e) A workers' compensation insurer; or

(f) Any other person, entity, policy or plan that is liable or legally responsible in relation to a Covered Person's Sickness or Injury.

2.67 **"Out-of-Pocket Expense Limitation"** has the meaning set forth in Section 10.04.

2.68 **"Part-Time Employee"** means an Employee characterized by an Employer as a part-time employee who regularly works less than 40, hours per week or, with respect to a Represented Employee, who regularly works such other period of time that is specified in the collective bargaining agreement covering such Employee as constituting part-time status for purposes of the Plan.

2.69 **"Participant"** means each Employee and Pre-65 Retiree who is a Covered Person.

2.70 **"Physician"** means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. 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 Physicians 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 the Plan shall be deemed to be a Physician.

2.71 **"Plan"** means the NiSource Consolidated Flex Medical Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.73 **"Plan Year"** means the calendar year.

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

2.75 **"Post-65 Retiree Medical Plan"** means the NiSource Post-65 Retiree Medical Plan, together with any and all amendments and supplements thereto, and any and all restatements thereof, from time to time.

2.76 **"Post-65 Retiree Plan Participant"** means a Post-65 Retiree who is properly enrolled in the Post-65 Retiree Medical Plan.

2.77 **"PPO Option"** means a Coverage Option offered through a preferred provider organization pursuant to Article VII.

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

2.79 **"Pre-Certification Provider"** means the entity retained by the Plan to pre-certify certain inpatient Hospital admissions and other specified procedures.

2.80 **"Pregnancy"** means the condition of being pregnant and all conditions and/or complications resulting therefrom.

2.81 **"Preventive Health Services"** means Recommended Preventive Health Services or Additional Preventive Health Services.

2.82 **"Provider"** has the same meaning as "Physician."

2.83 **"Qualified Beneficiary"** means:

(a) Any persons who were Covered Persons on the date immediately preceding a Qualifying Event as:

(1) An Employee;

(2) An Employee's Spouse; or

(3) A Dependent Child.

(b) A Child who is born to or placed for adoption with a Covered Employee who is a Qualified Beneficiary during a period of COBRA Continuation Coverage. The COBRA Continuation Coverage period for such a Qualified Beneficiary shall run from his or her birth or adoption to the end of the COBRA Coverage period for all Qualified Beneficiaries entitled to COBRA coverage as a result of the same Qualifying Event.

(c) In the case of a Qualifying Event described in subsection 2.84(g), a Retiree who retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such Qualifying Event, is a Covered Person as a Spouse, Dependent Child, or surviving Spouse.

2.84 **"Qualifying Event"** means any of the following that results in loss of coverage for a Qualified Beneficiary:

(a) The Covered Employee's employment ends (except in the case of gross misconduct);

(b) The Covered Employee's work hours are reduced;

(c) The Covered Employee becomes entitled to benefits under Medicare;

(d) The Covered Employee's death;

(e) The divorce or legal separation of the Covered Employee from the Covered Employee's Spouse;

(f) A Dependent Child is no longer an eligible Dependent; or

(g) With respect to a Retiree, a proceeding in a case under Title XI, United States Code, with respect to the Company. In the case of a Qualifying Event described in this subsection 2.84(g), a "loss of coverage" includes a substantial elimination of coverage with respect to a Qualified Beneficiary described in subsection 2.83(c) within one year before or after the date of commencement of the proceeding.

2.85 **"Recommended Preventive Health Services"** means those items and services described in 29 C.F.R. §2590.715-2713(a), or any successor regulation, but subject to the timing rules of 29 C.F.R. §2590.715-2713(b), or any successor regulation. For the avoidance of doubt, "Recommended Preventive Services" shall not include an item or service specified in a recommendation or guideline described in 29 C.F.R. §2590.715-2713(a)(1) or any successor regulation (a) earlier than the first day of the first Plan Year after the date the recommendation or guideline is issued or (b) after the end of the Plan Year in which the recommendation or guideline is no longer described in such regulations. Provided, however, that to the extent an item or service described in 29 C.F.R. §2590.715-2713(a)(1)(i) and covered on the first day of a Plan Year is, during such Plan Year, downgraded to a "D" rating, or any item of service associated with any recommendation or guideline described in 29 C.F.R. §2590.715-2713(a)(1) 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 item or service will cease to be a "Recommended Preventive Health Service" as of the date of the rating downgrade or agency determination. The frequency, method, treatment and setting of such items or services shall be subject to reasonable medical management techniques determined by the Plan Administrator or Claims Administrator in their discretion.

2.86 **"Related Employer"** means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.87 **"Relative"** means a person who is the Spouse, mother, father, sister, brother, Child or in-law of a Participant.

2.88 **"Represented"** means a Full-Time or Part-Time Employee or a Retiree who is covered by a collective bargaining agreement between an Employer and a union.

2.89 **"Retiree"** means a former Employee who retired from service with an Employer, in accordance with a plan or procedure adopted by the Employer, after having attained the age of 55 years and ten Years of Service. 'Retiree' also means a former Employee who retired from service with an Employer, in accordance with a plan or procedure adopted by the Employer and after ten Years of Service, but prior to attaining the age of 55 years, and who elects continued coverage under the Plan in lieu of COBRA Continuation Coverage pursuant to a written agreement entered into with an Employer. For purposes of this Section 2.89, "Years of Service" has the same meaning given such term in Section 4.01(c)(3). Notwithstanding the foregoing,

(a) A person who would otherwise meet the definition of "Retiree" shall not cease to be a Retiree solely because such person is rehired by an Employer to regularly work less than twenty hours per week;

(b) "Retiree" shall also mean any former Employee who qualifies as a Retiree under the Special Provisions described in Article IV;

(c) Upon reaching age 65, a Retiree shall be considered a Post-65 Retiree and, subject to the provisions of Section 22.05, shall no longer be eligible for coverage under the Plan;

(d) A person who would otherwise meet the definition of "Retiree" shall not be ineligible to be a Retiree solely because such person elected to retire from service with an Employer during a strike or lockout;

(e) A "Retiree" shall not include any former Employee who retired from employment with Lake Erie Land Company; and

(f) "Retiree" shall not include any person who is not a member of a Covered Retiree Group or who belongs to a Covered Retiree Group for which there is no Available Pre-65 Retiree Coverage Option.

Without limiting the generality of any other provision of the Plan, as of the Separation Date, the term 'Employer' for purposes of this Section 2.89 shall not include any Columbia Divested Company or any CPG Related Employer.

2.90 **"Room and Board Charges"** means an institution's charges for room, board and for other necessary institutional services and supplies, which are made regularly at a daily or weekly rate as a condition of occupancy.

2.91 **"Same-Sex Domestic Partner"** means, with respect to a Covered Participant, a person of the same sex as the Covered Participant, if the Covered Participant and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is the Covered Participant's registered domestic partner, or is a party to a civil union with the Covered Participant, under the laws of the Covered Participant's state of residence; or

(b) The Covered Participant and such person

(1) are both age 18 or older and competent to enter into a legal contract;

(2) have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are Financially Interdependent;

(3) share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in the Covered Participant's state of residence;

(4) reside in a state that, prior to June 26, 2015, did not recognize or permit same-sex marriage, domestic partner registration or civil union;

(5) are not currently married to, a party to a civil union with, or the domestic partner, of any other person;

(6) intend that their same-sex domestic partnership be of unlimited duration; and

(7) do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

Notwithstanding the foregoing, for any insured benefit option, a person shall not be a Same-Sex Domestic Partner if he is otherwise ineligible for coverage under the terms of the certificate of coverage, group insurance policy or other governing document for such benefit option.

From time to time, a Covered Participant may be required to confirm orally, electronically or in writing, in a manner prescribed by the Plan Administrator, that the Covered Participant and his or her Same-Sex Domestic Partner satisfy the foregoing eligibility requirements.

2.92 **"Semi-Private Rate"** means the daily Room and Board Charges that an institution applies to the greatest number of beds in its semi-private rooms containing two or more beds. If the institution has no semi-private rooms, the Semi-Private Rate shall be the daily Room and Board Charges most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. For purposes of this Section, "area" means a city, a county or any greater area necessary to obtain a representative cross-section of similar institutions.

2.93 **"Separation Date"** means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

2.94 **"Sickness"** means an illness causing loss commencing while the Plan is in force for a Covered Person. 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 Physician.

2.95 **"Special Enrollment Period"** means the enrollment periods offered under subsection 3.02(d).

2.96 **"Spouse"** means a person who is treated as a spouse under the Code.

2.97 **"Status Change"** means any of the following:

(a) Legal Marital Status. Events that change an Employee's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment.

(b) Number of Dependents. Events that change an Employee's number of Dependents, including birth, adoption, placement for adoption (as defined in Treasury Regulations under Code Section 9801), or death of a Dependent.

(c) Employment Status. A termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite that changes the employment status of an Employee, a Spouse or other Dependent, or any other change in the employment status of an Employee, a Spouse or other Dependent that makes such individual eligible or ineligible for coverage under the Plan (such as switching from full-time to part-time status or from salaried to hourly-paid).

(d) Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to marriage, attainment of age, student status, or any similar circumstance as provided in the Plan.

(e) Residence. A change in the place of residence of an Employee, a Spouse or other Dependent.

(f) Other Permissible Events. Any other event that the Plan Administrator or a member of the Committee determines to be a permissible Status Change under the Code or any regulation, ruling or release issued thereunder. Such determination shall be (1) consistent with the terms of the Plan; and (2) made in a uniform and non-discriminatory manner.

As used in this Section 2.97, and subject to the immediately following paragraph, the term "Dependent" shall include only those Dependents described in Section 2.32 above who would be considered a "dependent" for purposes of Code Section 125, the regulations thereunder, and

Internal Revenue Service Notice 2010-38, as such statutory provision, regulations or guidance may be amended or modified from time to time.

Solely for purposes of this Section 2.97 and Section 3.02(e), and only for the period beginning January 1, 2013, and ending on December 31, 2016, a "Spouse" will be deemed to include a Covered Participant's Same-Sex Domestic Partner, "marriage" will be deemed to include the establishment of a Same-Sex Domestic Partner relationship, "divorce" will be deemed to include the termination of a Same-Sex Domestic Partner relationship, and the term "Dependent" will be deemed to include a Same-Sex Domestic Partner and a Same-Sex Domestic Partner's Child; provided, however, that notwithstanding any other provision of the Plan, no Category of Coverage change under Section 3.02(e) involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee, in their sole discretion, or would violate the requirements of any insurer under any HMO Option or Other Insured Arrangement.

2.98 **"Stepchild"** means any natural or adopted child of a Covered Participant's current Spouse or Same-Sex Domestic Partner, and any natural or adopted child of a former Spouse or Same-Sex Domestic Partner of a Covered Participant living in the Covered Participant's home in a familial relationship if the natural parents of such child are both deceased.

2.99 **"Summary Plan Description"** means the summary plan description for the Plan.

2.100 **"Surgical Procedure"** means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

2.101 **"Urgent Hospitalization"** means a hospitalization that is necessary to address a condition occurring suddenly and unexpectedly and resulting in an urgent need for immediate medical attention because the Covered Person's life is endangered.

2.102 **"Well Newborn Child"** means a Newborn Child who does not require any unusual services or supplies during his or her initial Hospital confinement.

ARTICLE III
PARTICIPATION

3.01 **Eligibility**. Subject to the specific eligibility restrictions provided for each Coverage Option described in Articles IV through IX, Employees and Pre-65 Retirees shall be eligible to participate in the Plan, and their eligible Dependents and eligible Dependents of certain Post-65 Retirees may be enrolled for coverage under the Plan, as follows:

(a) Regular Employees. Each regular, Full-Time and Part-Time Employee of an Employer may be covered under the Plan on the first day of his or her active employment, providing he or she properly enrolls for coverage under Section 3.02. For new hires, such Employee must be actively at work on the date coverage is scheduled to begin.

(b) Temporary Employees. Each eligible Employee characterized by an Employer as a temporary employee may be covered under the Plan.

(c) Dependents. A Covered Participant's eligible Dependent who is properly enrolled for coverage under Section 3.02 shall be covered on the earliest of (1) January 1 after the Annual Enrollment Period in which a Covered Participant elects to cover such Dependent; (2) with respect to the Dependent of a Participant hired after January 1, the date the Participant's coverage becomes effective; (3) with respect to the Dependent of a Pre-65 Retiree or Post-65 Retiree Plan Participant, the date the Retiree's Retiree coverage becomes effective; or (4) the date coverage is provided under the provisions of subsections 3.02(d)-(j).

(d) Retirees. A Pre-65 Retiree may be covered under the Plan as of the date of his or her retirement if he or she properly enrolls for coverage under Section 3.02. The Committee reserves the right to amend or terminate the provisions for Retiree participation in the Plan in accordance with Article XXVI.

(e) No Double Coverage. Notwithstanding the foregoing, no person is eligible to be covered as both a Participant and a Dependent, nor may any person be covered as a Dependent of more than one Covered Person.

3.02 Enrollment. Subject to the specific eligibility restrictions provided for each Coverage Option described in Articles IV through IX, Employees, Pre-65 Retirees and Post-65 Retiree Plan Participants (on behalf of their eligible Dependents only) shall be eligible to enroll in the Plan as follows:

(a) New Hires. Each newly hired Employee who becomes eligible to become covered under subsections 3.01(a) or (b) shall be permitted to enroll such Employee and any Dependents such Employee desires to cover on or before the day the Employee first becomes eligible for coverage. Any enrollment will be effective for the period beginning on the first day of eligibility and ending on the last day of the Plan Year in which such participation begins. If a newly hired Employee fails to properly enroll, he or she shall be covered pursuant to Sections 3.05 and 3.06.

(b) Retirees. Each Pre-65 Retiree who becomes eligible to become covered under subsection 3.01(d) shall properly enroll such Pre-65 Retiree and any Dependents such Pre-65 Retiree desires to cover no later than the date of such Pre-65 Retiree's retirement. Such Pre-65 Retiree enrollment shall be effective on the date of the Pre-65 Retiree's retirement. A Pre-65 Retiree who fails to properly enroll pursuant to this subsection shall be covered, and such Pre-65 Retiree's Dependents shall be covered, pursuant to Sections 3.05 and 3.06.

(c) Annual Enrollment Period. An eligible Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents only), or Qualified Beneficiary may elect or change any Coverage Option during the Annual Enrollment Period. Such election shall be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year; provided, however, if such Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant or Qualified Beneficiary makes no election or change during the Annual Enrollment Period, such Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant or Qualified Beneficiary shall be deemed to have elected a Coverage Option for the following Plan Year as described in Section 3.05.

(d) Special Enrollment Periods.

(1) *Loss of Coverage.* If an Employee declined Plan participation for himself or herself, or declined coverage for a Spouse or Dependent, because he or she or the Spouse or Dependent was covered under another Group Health Plan or had other health insurance coverage when the Employee declined coverage, such Employee may apply for coverage and make any necessary Coverage Option change during the Special Enrollment Period provided under this subsection if the Employee, Spouse or Dependent loses the other coverage for reasons including, but not limited to:

(A) Loss of eligibility of coverage (other than failure to pay premiums or termination of coverage for cause);

(B) Termination of employer contributions under the other plan; or

(C) Exhaustion of COBRA continuation coverage.

If requested, such Employee must have stated when he or she declined coverage under the Plan that he or she declined coverage because of such other coverage.

The Special Enrollment Period offered pursuant to this subsection shall begin on the date the other coverage was lost and shall expire 31 days thereafter. Accordingly, to become covered under this subsection, the Employee shall properly enroll for coverage within such Special Enrollment Period. If the Employee so properly enrolls, coverage under this subsection shall be effective as of the date such enrollment is approved by the Plan.

(2) *Newly Acquired Dependent.* If an eligible Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant or Qualified Beneficiary acquires a Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant or Qualified Beneficiary may apply for coverage for any such Spouse or Dependent (and the Employee if not previously covered) and make any necessary Coverage Option change during the Special Enrollment Period provided under this subsection.

The Special Enrollment Period offered pursuant to this subsection shall begin on the date of the marriage, birth, adoption or placement for adoption, and shall expire 31 days thereafter. Accordingly, to become covered under this subsection, the Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant or Qualified Beneficiary shall properly enroll for coverage within such Special Enrollment Period. If the Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant or Qualified Beneficiary so properly enrolls, coverage under this subsection shall be effective as of the beginning of the Special Enrollment Period.

Solely for purposes of this subsection (d)(2), and only for the period beginning January 1, 2013, and ending on December 31, 2016, the term "Spouse" shall include a Same-Sex Domestic Partner and the term "marriage" shall include the establishment of a Same-Sex Domestic Partner relationship.

(3) *Gain or Loss of Eligibility for Medicaid or State Child Health Plan Coverage.* An eligible Employee who has not enrolled for coverage under the Plan (or who

has not enrolled his or her Dependent for coverage under the Plan) may apply for coverage and make any necessary Coverage Option changes during the Special Enrollment Period provided under this subsection if the Employee (or his or her eligible Dependent) either

(A) Was covered under a Medicaid plan or under a State child health plan under title XXI of the Social Security Act of 1965, as amended, and coverage of the Employee or Dependent under such a plan was terminated as a result of loss of eligibility for such coverage; or

(B) Becomes eligible for assistance, with respect to coverage under the Plan, under a Medicaid plan or under a State child health plan under title XXI of the Social Security Act of 1965, as amended, (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Special Enrollment Period offered pursuant to this subsection (d)(3) shall begin on the date coverage under the Medicaid plan or State child health plan was terminated or the date the Employee or Dependent is determined to be eligible for assistance with respect to coverage under the Plan, and shall expire 60 days thereafter. Accordingly, to become covered under this subsection, the Employee shall properly enroll for coverage within such Special Enrollment Period. If the Employee so properly enrolls, coverage under this subsection shall be effective as of the date such enrollment is approved by the Plan.

(e) Status Change Enrollment. If a Status Change occurs, an Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents only) may make a Category of Coverage change during the Status Change Enrollment Period provided under this subsection; provided, however, if required by Section 125 of the Code and the Regulations, rulings and releases issued thereunder, such Category of Coverage change shall be consistent with the Status Change event. A Category of Coverage change is consistent with a Status Change event if, and only if, (1) the Status Change results in an Employee, Pre-65 Retiree or Dependent gaining or losing eligibility for coverage under either the Plan or an accident or health plan of the Dependent's employer; and (2) the Category of Coverage change corresponds with such gain or loss of coverage.

Such Status Change Enrollment Period shall begin on the date of the Status Change event, and shall expire 31 days thereafter. Accordingly, to obtain or modify coverage under this subsection, the Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant shall properly modify his or her enrollment during such Status Change Enrollment Period. Any Category of Coverage change under this subsection shall be effective as of the date it is approved by the Plan.

(f) Judgment, Decree or Order. An Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant may make a Category of Coverage change upon entry of a court judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in Section 609 of ERISA) that requires Plan coverage for a Child.

(g) Entitlement to Medicare or Medicaid. An Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant may make a Category of Coverage change if a Covered Person becomes

enrolled under Medicare Parts A, B or C, or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). Any such Category of Coverage change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan for Employees.

(h) Automatic Cost Change. If the cost of the Plan increases or decreases during a Plan Year, a Covered Participant is required to make a corresponding change in his or her payments under the Plan. In such event, on a prospective basis, the Plan Administrator shall automatically effectuate the increase or decrease in the Covered Participant's elective Covered Person Contributions. In addition, the Plan Administrator may automatically make a prospective decrease in a Covered Participant's elective Covered Person Contributions as a result of any event that causes the Covered Participant to lose eligibility for coverage.

(i) Significant Cost Change. An Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant may make a Coverage Option change if the cost of a Coverage Option under the Plan significantly increases or decreases during a Plan Year. Any Coverage Option change must correspond with such increase or decrease in cost. Changes that are permitted include commencing participation in a Coverage Option that significantly decreases in cost, or, in the case of an Coverage Option that significantly increases in cost, revoking an election for that Coverage Option and, in lieu thereof, either receiving on a prospective basis coverage under another Coverage Option providing similar coverage or dropping the Coverage Option if no other Coverage Option providing similar coverage is available. Any such Coverage Option change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan for Employees.

(j) Significant Coverage Change. An Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant may make a Coverage Option change:

(1) If the coverage under a Coverage Option is significantly curtailed during a period of coverage, in which case the Participant or Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents only) may revoke his or her election for coverage under such Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Coverage Option providing similar coverage;

(2) If the coverage under a Coverage Option ceases during a period of coverage, in which case the Participant or Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents only) may revoke his or her election for coverage under such Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Coverage Option providing similar coverage, or elect the No Coverage Option if no Coverage Option providing similar coverage is available;

(3) If the Plan adds a new benefit or other coverage option or the terms of a benefit offered under the Plan are significantly improved during a period of coverage; or

(4) On account of and corresponding with a change made under another employer's plan if (i) the other cafeteria plan or qualified benefits plan permits participants to make an election that is consistent with the permitted election change rules under Section 125 of the Code and the regulations issued thereunder, or (ii) the Plan

permits Covered Participants to make an election for a period of coverage that is different from the period of coverage under the other employer's cafeteria plan or qualified benefits plan.

Any such Coverage Option change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan for Employees.

(k) Retirement. An Employee may make a Coverage Option and Category of Coverage change upon retirement.

(l) Election Changes involving the HMO Option or Other Insured Arrangements. Notwithstanding any other provision of the Plan, enrollment or a change in enrollment in any HMO Option or Other Insured Arrangement shall be subject to any additional terms or conditions imposed by the insurer under such HMO Option or Other Insured Arrangement.

(m) Changes Involving Same-Sex Domestic Partners. Notwithstanding any provision of this Section 3.02, no Category of Coverage change, Coverage Option change, or change in Covered Person Contributions in respect of an event involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or of any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee in their sole discretion, or would violate the requirements of any insurer under any HMO Option or Other Insured Arrangement.

(n) Enrollment of Same-Sex Domestic Partners and Their Children. Effective January 1, 2017, no Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant may enroll a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's child for coverage under the Plan.

3.03 Categories of Coverage. The Plan offers the following Categories of Coverage within each Coverage Option:

(a) Employee- or Retiree-Only;

(b) Employee or Retiree + Spouse (not available for the HD PPO Options described in Article VI);

(c) Employee or Retiree + Child (not available for the HD PPO Options described in Article VI);

(d) Employee or Retiree + Family;

(e) Spouse-Only (only in case of Spouse of a Post-65 Retiree Plan Participant);

(f) Spouse + Child(ren) (only in case of a Spouse and Child(ren) of a Post-65 Retiree Plan Participant);

(g) Child(ren)-Only (only in case of Child(ren) of a Post-65 Retiree Plan Participant); and

(h) No Coverage.

Where applicable, Categories of Coverage include an eligible Same-Sex Domestic Partner and an eligible Child of a Same-Sex Domestic Partner.

3.04 **Opt-Out Credit**. An Employee who elects the No Coverage Option under the Plan for himself or herself and his or her Dependents shall receive an Opt-Out Credit (of an amount determined by the Plan Administrator) on a monthly basis (unless otherwise agreed pursuant to an applicable collective bargaining agreement) until he or she ceases to be eligible to participate in the Plan. Notwithstanding anything contained herein to the contrary, (i) a Part-Time Employee shall not be eligible for an Opt-Out Credit; and (iii) an Employee who elects the No Coverage Option under the Plan for himself or herself, but who is covered under the Plan as a Dependent, is not entitled to an Opt-Out Credit.

3.05 **Election of a Coverage Option**. An Employee may select a Coverage Option as a new hire or during the Annual Enrollment Period, a Pre-65 Retiree may select a Coverage Option as a new Retiree, and a Post-65 Retiree Plan Participant may select a Coverage Option for his or her eligible Dependents upon becoming a Post-65 Retiree. Such an Option selection shall remain effective until properly changed during an Annual Enrollment Period or by reason of an event described in subsections 3.02(d)-(k).

(a) If a newly hired Employee or a new Pre-65 Retiree fails to properly enroll for coverage, such Employee or Pre-65 Retiree shall be deemed to have selected the following Coverage Options:

(1) Represented Employees shall be deemed to have selected the PPO Option.

(2) Non-Represented Employees shall be deemed to have selected the HD PPO 2 Option.

(3) A Pre-65 Retiree shall be deemed to have selected the Coverage Option that was in effect on the date immediately preceding such Pre-65 Retiree's retirement.

(4) Notwithstanding the foregoing, Represented Bay State Gas Company Employees who are represented by the International Brotherhood of Electrical Workers Local Union No. 486 shall be deemed to have elected the HMO Option, as more particularly defined by the Plan Administrator.

(b) If a new Post-65 Retiree Plan Participant fails to properly enroll his or her eligible Dependents for coverage, such Post-65 Retiree Plan Participant shall be deemed to have continued in effect the Coverage Options for his or her eligible Dependents that were in effect on the date immediately preceding the Post-65 Retiree Plan Participant's enrollment in the Post-65 Retiree Medical Plan.

(c) If an Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents) fails to properly enroll for coverage during the Annual Enrollment Period, such Employee, Pre-65 Retiree or Post-65 Retiree Plan Participant shall be deemed to have selected the following Coverage Options:

(1) Non-Represented Employees and Retirees who formerly were Non-Represented Employees shall be deemed to have selected the same Coverage Option in place at the beginning of the Annual Enrollment Period. However, if the Company requires affirmative enrollment, Non-Represented Employees and Retirees who

formerly were Non-Represented Employees shall be deemed to have selected the HD PPO 1 Option.

(2) Represented Employees and Retirees who formerly were Represented Employees shall be deemed to have selected the same Coverage Option in place at the beginning of the Annual Enrollment Period. However, if the Company requires affirmative enrollment, such Represented Employees and Retirees who formerly were Represented Employees shall be deemed to have selected the PPO Option.

(3) Notwithstanding the foregoing, Represented Bay State Gas Company Employees who are represented by the International Brotherhood of Electrical Workers Local Union No. 486 shall be deemed to have selected the same Coverage Option in place at the beginning of the Annual Enrollment Period. However, if the Company requires affirmative enrollment, such Employees shall be deemed to have elected the HMO Option, as more particularly defined by the Plan Administrator.

(d) A Pre-65 Retiree or Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents) may change a Coverage Option to the No Coverage Option at any time during the Plan Year; provided, however, that no further change in Coverage Option may be made except in connection with an Annual Enrollment Period or by reason of an event described in subsections 3.02(d)-(k).

3.06 Election of a Category of Coverage. An Employee, Pre-65 Retiree, Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents only) or Qualified Beneficiary may select or change a Category of Coverage during the enrollment periods set forth in Section 3.02 and subject to any requirements or limitations under the Flexible Benefits Plan. Any such selection shall remain effective until properly changed by an Employee or Retiree during an Annual Enrollment Period, or by reason of an event described in subsections 3.02(d)-(k). If a new hire fails to properly enroll, such new hire shall be deemed to have selected Employee-Only coverage. If a new Pre-65 Retiree fails to properly enroll for coverage, such Pre-65 Retiree shall be deemed to have selected the same (or analogous) Category of Coverage that was in effect immediately before such Pre-65 Retiree's retirement. A Pre-65 Retiree or Post-65 Retiree Plan Participant (on behalf of his or her eligible Dependents) may change his or her Category of Coverage to No Coverage at any time during the Plan Year; provided, however, that no further change of Category of Coverage may be made except in connection with an Annual Enrollment Period or by reason of an event described in subsections 3.02(d)-(k)

ARTICLE IV
RETIREE COVERAGE

4.01 Participation in Coverage Options.

(a) Eligibility.

(1) Subject to the provisions of Article III, prior to any such person attaining age 65, a Pre-65 Retiree, his or her Dependents, and each Dependent of a Post-65 Retiree Plan Participant shall be eligible to participate in an Available Pre-65 Retiree Coverage Option.

(2) Upon attaining age 65, (i) a Pre-65 Retiree becomes a Post-65 Retiree and is no longer eligible for coverage under the Plan, and (ii) a Dependent of a Pre-65 Retiree or Post-65 Retiree Plan Participant is no longer eligible for coverage under the Plan.

(b) Enrollment. Subject to the provisions of Article III, a person described in Section 4.01(a)(1) above may enroll or be enrolled in an Available Pre-65 Retiree Coverage Option or may elect or have elected for him or her the No Coverage Option. Provided, however, that effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child may be enrolled in coverage under the Plan.

(c) Contributions. The following provisions apply with respect to contributions toward the cost of coverage under the Plan:

(1) A Pre-65 Retiree who participates in an Available Pre-65 Retiree Coverage Option shall be required to contribute toward his or her coverage, and such Participant or a Post-65 Retiree Plan Participant shall be required to contribute toward the coverage of his or her Dependents who are covered under the Plan, in an amount as determined from time to time by the Plan Administrator.

(2) If a Pre-65 Retiree or Post-65 Retiree Plan Participant is a member of a Covered Retiree Group for which a Defined Dollar Subsidy or other premium subsidy is made available, as indicated by Schedule 1 attached hereto, such Pre-65 Retiree, and the Spouse or Same-Sex Domestic Partner of any such Pre-65 Retiree or Post-65 Retiree Plan Participant, if the Spouse or Same-Sex Domestic Partner is under age 65 and a Covered Person, shall be credited with an annual Defined Dollar Subsidy or other premium subsidy, as applicable, toward the cost of coverage in the amount indicated by Schedule 1. The Pre-65 Retiree or Post-65 Retiree Plan Participant, as the case may be, shall remain responsible for the cost of coverage to the extent such cost exceeds the Defined Dollar Subsidy or other premium subsidy.

(3) The Defined Dollar Subsidy for an eligible Pre-65 Retiree is an annual amount to be applied toward the cost of coverage under the Plan that is equal to the product of (i) a dollar value, as specified in Schedule 1 attached hereto, multiplied by (ii) the Pre-65 Retiree's Years of Service. The Defined Dollar Subsidy for a Covered Participant's Spouse or Same-Sex Domestic Partner who is a Covered Person is an annual amount to be applied toward the cost of coverage for the Spouse or Same-Sex Domestic Partner under the Plan that is equal to the product of (i) a dollar value, as specified in Schedule 1 attached hereto, multiplied by (ii) the Covered Participant's Years of Service. For purposes of this Section 4.01(c)(3) only, "Years of Service" equals the total number of Years of Service at retirement, rounded up to the nearest whole number, earned by the Pre-65 Retiree or Post-65 Retiree Plan Participant for purposes of benefit accrual (including all service prior to a distribution that causes any prior service to be disregarded) under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan. Notwithstanding the foregoing, for purposes of the Special Provisions Applicable to Certain Outsourced and Severed Employees described in Section 4.03, "Years of

Service" for purposes of this Section 4.01(c)(3) shall mean "Years of Service" as defined in subsection 4.03(d).

(4) If a Pre-65 Retiree or Post-65 Retiree Plan Participant dies prior to his or her eligible Spouse or Same-Sex Domestic Partner, the surviving Spouse or Same-Sex Domestic Partner, if under age 65, shall be credited with a Defined Dollar Subsidy in the same amount as a Pre-65 Retiree who is a member of the same Covered Retiree Group as the Pre-65 Retiree or Post-65 Retiree Plan Participant.

(5) Contributions shall also be governed by Article XI. The Committee reserves the right to modify these contribution provisions from time to time.

(d) Rehires. A Retiree who is rehired by an Employer and subsequently retires shall be considered a member of the Covered Retiree Group applicable to such Retiree as of the date of his or her latest retirement.

4.02 Special Provisions Applicable to 2002 NiSource Organization Restructuring. From August 28, 2002, through December 31, 2002, certain Employees were notified of their involuntary separation under the 2002 NiSource Inc. Organization Restructuring (the "2002 Restructuring"). The purpose of this Section is to specify the special provisions that apply to Employees who were eligible for and elected the Defined Dollar Subsidy for retiree medical coverage offered pursuant to the 2002 Restructuring.

(a) Retiree Medical Benefits Offered in Connection with the 2002 NiSource Inc. Organization Restructuring.

An Employee who:

(1) Was notified of his or her involuntary separation from an Employer under the 2002 Restructuring between August 28, 2002 and December 31, 2002;

(2) Elected salary continuation as his or her severance benefit option and, at the end of the salary continuation period, was age 50 to 54 with 10 Years of Service;

(3) Properly executed the release attached to his or her Severance Agreement in accordance with the procedures set forth in that Severance Agreement, or if appropriate, any subsequently tendered release from the Company or an affiliate thereof; and

(4) Was eligible for and elected the Defined Dollar Subsidy offered in connection with the 2002 Restructuring,

shall be eligible, subject to the other provision of Article IV, including without limitation Section 4.01(a), for retiree medical coverage under any Coverage Option and shall be credited with an annual Defined Dollar Subsidy toward the cost of such coverage. The Pre-65 Retiree or Post-65 Retiree Plan Participant shall remain responsible for the annual cost of coverage to the extent such cost exceeds the Defined Dollar Subsidy equal to the applicable amount set forth in subsection 4.02(b).

(b) Pre-Medicare Defined Dollar Subsidy. Before the date the former Employee becomes eligible for Medicare coverage, the annual Defined Dollar Subsidy shall equal $180 times Years of Service towards coverage for the Pre-65 Retiree, and $125 times Years of

Service towards coverage for such Spouse, if any, of a Pre-65 Retiree or Post-65 Retiree Plan Participant.

(c) Years of Service. For purposes of this Section only, "Years of Service" equals the total number of Years of Service at retirement, rounded up to the nearest whole number, earned by the Pre-65 Retiree or Post-65 Retiree Plan Participant for purposes of benefit accrual (including all service prior to a distribution that causes any prior service to be disregarded) under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan.

4.03 Special Provisions Applicable to Certain Outsourced and Severed Employees. Notwithstanding any provision of the Plan to the contrary, any Participant who (i) was notified in writing on June 21, 2005, or any following date up to and including December 31, 2005, that his or her employment was outsourced to International Business Machines Corporation (the "IBM Outsourcing"), (ii) received an initial Severance Letter Agreement dated on June 21, 2005, or any following date up to and including December 31, 2005, from the Company in connection with the IBM Outsourcing, (iii) elected by January 10, 2006 to be part of the termination from service window offered to employees eligible for the NiSource Inc. Executive Severance Policy, or (iv) was otherwise terminated from employment in connection with the 2005/2006 corporate restructuring on or before March 31, 2006, as reflected in his termination letter, shall be considered a Retiree and, subject to the other provisions of Article IV, including without limitation Section 4.01(a), shall be eligible for retiree medical coverage under any Coverage Option as follows:

(a) Each Participant who was age 50 to 54 with at least 10 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree upon reaching age 55;

(b) Each Participant who was age 55 or over with 5 to 9 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree as of the date that such individual would have completed 10 Years of Service had he or she continued to be employed by the Company or a Related Employer but for the IBM Outsourcing or related severance; and

(c) Each Participant who was age 50 or over with 5 to 9 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree as of the date that such individual reaches age 55 and would have completed 10 Years of Service had he or she continued to be employed by the Company or a Related Employer but for the IBM Outsourcing or related severance.

(d) For purposes of this Section 4.03 and Section 4.01, "Years of Service" equals the number of Years of Service earned by a former Employee towards eligibility for an early retirement pension under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee participated, as calculated under the terms of each applicable defined benefit pension plan; provided, however, that Years of Service shall not include any pension service time added as a result of the IBM Outsourcing or severance in connection with the IBM Outsourcing.

4.04 Special Provisions Applicable to Pre-65 Retirees and Post-65 Retiree Plan Participants Who are Former Represented Employees.

(a) Eligibility. Notwithstanding any other provision in Article IV, Pre-65 Retirees (and their Dependents) and Post-65 Retiree Plan Participants (with respect to coverage of eligible Dependents only) who retired from employment with an Employer as Represented Employees shall be eligible for coverage under this Article IV only to the extent provided by the respective collective bargaining agreements applicable to such Retirees as former Represented Employees.

(b) Contributions. Notwithstanding any other provision in Article IV, Pre-65 Retirees and Post-65 Retiree Plan Participants (with respect to coverage of eligible Dependents only) who retired from employment with an Employer as Represented Employees shall be required to contribute to coverage under this Article IV as provided by the respective collective bargaining agreements applicable to such Retirees as former Represented Employees.

ARTICLE V
RESERVED

ARTICLE VI
HD PPO OPTIONS

6.01 Eligibility. Subject to the provisions of Articles III and IV, the HD PPO Options shall be available to all Full-Time Employees and Part-Time Employees and their Dependents, to Pre-65 Retirees (and their Dependents) for whom such Options are Available Pre-65 Retiree Coverage Options, and to all Dependents of Post-65 Retiree Plan Participants for whom such Options are Available Pre-65 Retiree Coverage Options. Notwithstanding the foregoing, the HD PPO Options shall not be available to Employees of Bay State Gas Company who are represented by the International Brotherhood of Electrical Workers Local Union No. 486 (Northampton) or to their Dependents.

6.02 Participating Providers. The Plan shall make available to each Covered Participant a list of participating providers in the HD PPO Options. If a Covered Participant resides outside the HD PPO Option coverage area, he or she shall receive "Out-of-Area" benefits. A Covered Participant shall be deemed to be "Out-of-Area" if he or she does not have a minimum of (1) two primary Physicians within ten miles of his or her residence; and (2) one network Hospital with 30 miles of his or her primary residence. In such circumstances, Physicians and Hospitals located within such 30-mile area shall be considered to be In-Network.

6.03 HD PPO Options. The Plan offers two HD PPO Options. Both HD PPO Options shall cover the same Covered Expenses. The HD PPO Options shall consist of HD PPO 1 and HD PPO 2 as follows:

(a) Self-Only (includes Employee- or Retiree-Only; Spouse-Only; and Child-Only).

Options	Annual Deductible	Covered Percentage	Co-Insurance	Out-of-Pocket Expense Limitation†
HD PPO 1 In-Network	$1,500	80%	20%	$3,000
HD PPO 1 Out-of-Network	$1,500	60%	40%	$4,500
HD PPO 2 In-Network	$2,500	80%	20%	$5,000
HD PPO 2 Out-of-Network	$2,500	60%	40%	$7,500

† Includes Deductible, but does not include premiums, balance billed charges, penalties for non-compliance or expenses not covered by the Plan

(b) Family (includes Employee or Retiree + Family; Employee or Retiree + Spouse; Employee or Retiree + Child; Spouse + Children; and Children-Only).

Options	Annual Deductible	Covered Percentage	Co-Insurance	Out-of-Pocket Expense Limitation†
HD PPO 1 In-Network	$3,000	80%	20%	$6,000
HD PPO 1 Out-of-Network	$3,000	60%	40%	$9,000
HD PPO 2 In-Network	$5,000	80%	20%	$10,000 (but each Covered Person subject to no more than the HHS Cost Limit††)
HD PPO 2 Out-of-Network	$5,000	60%	40%	$15,000 (but each Covered Person subject to no more than $10,000)

† Includes Deductible, but does not include premiums, balance billed charges, penalties for non-compliance or expenses not covered by the Plan

†† "HHS Cost Limit" means the annual limitation on cost-sharing for self-only coverage for the Plan Year in question, as adjusted from time to time, as determined in accordance with 45 C.F.R. §156.130(a)(2)(i) or any successor regulation.

6.04 **Health Savings Accounts**. Participants who elect the HD PPO Options, and certain Dependents of Post-65 Retiree Plan Participants who are covered under the HD PPO Options, may be eligible to contribute to a health savings account under the Flexible Benefits Plan. Subject to the terms, conditions and limitations of the Flexible Benefits Plan, the Company may make a health savings account contribution through the Flexible Benefits Plan on behalf of any Participant who elects coverage under HD PPO 1 or HD PPO 2. In addition, subject to any limitations imposed by the Code or any regulations thereunder, and subject to the terms of any applicable collective bargaining agreement, the Company may make a one-time health savings account contribution on

behalf of any Participant who (i) is a former NIPSCO Represented Employee and an eligible Retiree hereunder, (ii) retires on or after January 1, 2015 and before January 1, 2020, (iii) timely elects HD PPO 1 or HD PPO 2 coverage and the Defined Dollar Subsidy in conjunction with his retirement in accordance with procedures established by the Company, and (iv) is eligible to contribute to a health savings account.

ARTICLE VII
PPO OPTION

7.01 Eligibility. Subject to the provisions of Articles III and IV, the PPO Option shall be available to all Full-Time Employees and Part-Time Employees and their Dependents, to all Pre-65 Retirees (and their Dependents) for whom such Option is an Available Pre-65 Retiree Coverage Option, and to all Dependents of Post-65 Retiree Plan Participants for whom such Option is an Available Pre-65 Retiree Coverage Option. Notwithstanding the foregoing the PPO Option shall not be available to Employees of Bay State Gas Company who are represented by the International Brotherhood of Electrical Workers Local Union No. 486 (Northampton) or to their Dependents.

7.02 Participating Providers. The Plan shall make available to each Covered Participant a list of participating providers in the PPO Option. If a Covered Participant resides outside the PPO Option coverage area, he or she shall receive "Out-of-Area" benefits. A Covered Participant shall be deemed to be "Out-of-Area" if he or she does not have a minimum of (1) two primary Physicians within ten miles of his or her residence; and (2) one network Hospital with 30 miles of his or her primary residence. In such circumstances, Physicians and Hospitals located within such 30-mile area shall be considered to be In-Network.

7.03 PPO Option. The Plan offers one PPO Option as follows:

(a) Employee- or Retiree-Only

Options	Individual Annual Deductible	Covered Percentage	Co-Insurance	Physician Office Visit Cost to Participant	Specialist Office Visit Cost to Participant	Emergency Room (Accidents) Cost to Participant	Annual Out-of-Pocket Expense Limitation††
PPO In-Network	$500	80%	20%	$35†	$40†	$150†	$1,500
PPO Out-of-Network	$1,000	60%	40%	40% after deductible	40% after deductible	0%	$3,000

† Does not apply toward any Deductible
†† Does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan

(b) Employee or Retiree + Spouse or Child(ren).

Options	Family Annual Deductible	Covered Percentage	Co-Insurance	Physician Office Visit Cost to Participant	Specialist Office Visit Cost to Participant	Emergency Room (Accidents) Cost to Participant	Annual Out-of-Pocket Expense Limitation††
PPO In-Network	$1,000	80%	20%	$35†	$40†	$150†	$3,000
PPO Out-of-Network	$2,000	60%	40%	40% after deductible	40% after deductible	0%	$6,000

† Does not apply toward any Deductible
†† Does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan

(c) Employee or Retiree + Family.

Options	Family Annual Deductible	Covered Percentage	Co-Insurance	Physician Office Visit Cost to Participant	Specialist Office Visit Cost to Participant	Emergency Room (Accidents) Cost to Participant	Annual Out-of-Pocket Expense Limitation††
PPO In-Network	$1,500	80%	20%	$35†	$40†	$150†	$4,500
PPO Out-of-Network	$3,000	60%	40%	40% after deductible	40% after deductible	0%	$9,000

† Does not apply toward any Deductible
†† Does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan

7.04 Special NIPSCO Union Provisions. Notwithstanding the provisions of Section 7.03, for the PPO Option, the Annual Deductible, Covered Percentage, Co-Insurance, Office Visit Cost to Participant and Annual Out-of-Pocket Expense Limitation for Represented Employees employed by NIPSCO, and for Retirees who were former Represented Employees of NIPSCO, are as follows:

(a) Employee- or Retiree-Only.

Options	Individual Annual Deductible	Covered Percentage	Co-Insurance	Office Visit Cost to Participant	Annual Out-of-Pocket Expense Limitation††
PPO In-Network	$300	80%	20%	$20†	$1,300
PPO Out-of-Network	$600	60%	40%	40%. after deductible	$2,600

† Does not apply toward any Deductible
†† Does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan

(b) Employee or Retiree + Spouse or Child(ren).

Options	Family Annual Deductible	Covered Percentage	Co-Insurance	Office Visit Cost to Participant	Annual Out-of-Pocket Expense Limitation††
PPO In-Network	$600	80%	20%	$20†	$2,600
PPO Out-of-Network	$1,200	60%	40%	40%. after deductible	$5,200

† Does not apply toward any Deductible
†† Does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan

(c) Employee or Retiree + Family.

Options	Family Annual Deductible	Covered Percentage	Co-Insurance	Office Visit Cost to Participant	Annual Out-of-Pocket Expense Limitation††
PPO In-Network	$900	80%	20%	$20†	$3,900
PPO Out-of-Network	$1,800	60%	40%	40% after deductible	$7,800

† Does not apply toward any Deductible
†† Does not include premiums, prescription drug expenses, balanced billed charges and expenses not covered under Plan

ARTICLE VIII
HMO OPTION

The Plan may make an HMO Option available. The terms and conditions applicable to such Option shall be contained in the certificate of coverage, the group insurance policy, and other applicable governing documents, which are incorporated herein by reference.

ARTICLE IX
OTHER INSURED ARRANGEMENT OPTION

The Plan may make an Other Insured Arrangement Option available. The terms and conditions applicable to such Option shall be contained in applicable certificates of coverage, any applicable group insurance policy, and other applicable governing documents, which are incorporated herein by reference.

ARTICLE X
PARTICIPANT PAYMENTS AND LIMITS

10.01 Deductible. The 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. Any Covered Expenses applied to the In-Network Deductible shall also apply to the Out-of-Network Deductible, and any Covered Expenses applied to the Out-of-Network Deductible shall also apply to the In-Network Deductible.

(a) PPO Option. Regardless of the Category of Coverage chosen, the Individual Deductibles for the PPO Option apply separately to each Covered Person each Plan Year. The Individual Deductible shall be considered met by the Participant and by all covered Dependents for the Plan Year if the Employee's or Retiree's Family meets the Family Deductible in that year. In determining whether the Family Deductible has been met for a Plan Year, the Individual Deductibles of those Family members who have satisfied the Individual Deductible are added together. If one Covered Person of the Employee's or Retiree's Family meets the Individual Deductible, the annual deductible requirement is considered met for that Covered Person. The applicable Deductibles are set forth in Articles VII and XV. The Plan shall not pay any amount until either (1) a Covered Person incurs Covered Expenses in a Plan Year in excess of the applicable Individual Deductible; or (2) an Employee's or Retiree's Family incurs Covered Expenses in a Plan Year in excess of the applicable Family Deductible. Covered Expenses that were incurred in the last three months of the Plan Year and applied to the individual Deductible and Family Deductible for such Plan Year, shall also apply to satisfying the Deductibles for the following Plan Year. With respect to the PPO Option, prescription drug expenses shall not be applied toward the Deductible.

(b) HD PPO Options. The applicable Deductibles are set forth in Article VI.

(1) If an Employee or Retiree elects the Employee- or Retiree-Only Category of Coverage, no amount is payable under the Plan until the Participant satisfies the annual individual deductible.

(2) If an Employee or Retiree elects the Employee or Retiree + Family Category of Coverage, no amount is payable under the Plan until the Employee and his or her Family satisfy the annual Family deductible.

10.02 Co-Insurance. After Covered Expenses incurred in a calendar year equal the Deductible amount, the Plan will pay the Covered Percentage of Covered Expenses (not exceeding the Maximum Allowed Amount) thereafter incurred in that calendar year. The Covered Participant shall be responsible for any applicable Co-Insurance. Applicable Covered Percentages and Co-Insurance are set forth herein and, to the extent not set forth herein, are set forth in an applicable Summary Plan Description.

10.03 Co-Payments. A Co-Payment applies to certain Covered Expenses. Applicable Co-Payments are set forth herein and, to the extent not set forth herein, are set forth in an applicable Summary Plan Description.

10.04 Out-of-Pocket Expense Limitation. The out-of-pocket expenses of a Covered Person for Co-Insurance, Co-Payments, Deductibles and any other expenditure referred to in Section 1302(c)(3) of the Affordable Care Act during any Plan Year shall be limited to the amount set forth in Articles VI, VII and XIV. Once the applicable Out-of-Pocket Expense Limitation has been reached in a particular Plan Year, no further Co-Insurance shall be required to be paid during the balance of that Plan Year. Any out-of-pocket expenses applied to the In-Network Out-of-Pocket Expense Limitation shall also apply to the Out-of-Network Out-of-Pocket Expense Limitation, and any out-of-pocket expenses applied to the Out-of-Network Out-of-Pocket Expense Limitation shall also apply to the In-Network Out-of-Pocket Expense Limitation.

10.05 Schedule of Co-Payments and Deductibles.

(a) Co-Payments shall apply to the following Covered Expenses for each arrangement as indicated below if performed In-Network:

Covered Expense	HD PPO 1	HD PPO 2	PPO Non-NIPSCO Union	PPO NIPSCO Union
Office Visits	N/A	N/A	$35*	$20*
Office Visits - Specialists	N/A	N/A	$40	$20
Office Visits – Allergy Testing	N/A	N/A	$40	$20
Emergency Room Visits/Accident (True Emergencies)	N/A	N/A	$150	N/A
Emergency Room Visits/Urgent Care	N/A	N/A	$35	$20
Emergency Room Visits/Non-Accident (True Emergency)/Non-Urgent Care	N/A	N/A	N/A	N/A
Pre-Natal Office Visits (first visit only)	N/A	N/A	$40	$20
Outpatient Physical, Occupational & Speech Therapy	N/A	N/A	$40	$20
Outpatient Physician Services	N/A	N/A	$40	$20
Recommended Preventive Health Services	N/A	N/A	N/A	N/A
Additional Preventive Health Services	N/A	N/A	N/A	N/A
Second Surgical Opinion	N/A	N/A	$40**	$20

* Co-pay does not apply to allergy injections, shots, serums and immunizations when no office visit is billed.
** Co-pay is $35 if the second surgical opinion is provided by a primary care physician.

(b) The applicable Deductible for the HD PPO Options shall apply to all of the Covered Expenses listed below except Preventive Health Services and Hearing Exams during Well Child office visits.

The applicable Deductible for the PPO Option shall apply to the Covered Expenses listed below as indicated.

Covered Expense	PPO Option In-Network	PPO Option Out-of-Network
Inpatient Room and Board	Yes	Yes
Inpatient Ancillary Services	Yes	Yes
Urgent Care	No	Yes
Emergency Room (accident)	No	No
Emergency Room (non-accident)	Yes	Yes
Inpatient Physician Services	Yes	Yes
Outpatient Physician Services	No	Yes
Private Duty Nursing	Yes	Yes
Preventive Health Services	No	Yes
Inpatient Surgery	Yes	Yes
Outpatient Surgery	Yes	Yes
Second Surgical Opinions	No	Yes
Dental/Oral Surgery	Yes	Yes
Inpatient Therapy	Yes	Yes

Covered Expense	PPO Option In-Network	PPO Option Out-of-Network
Outpatient Therapy	No	Yes
Inpatient Radiology	Yes	Yes
Outpatient Radiology	Yes	Yes
Inpatient Pathology	Yes	Yes
Outpatient Pathology	Yes	Yes
Hospice	Yes	Yes
Skilled Nursing Facility	Yes	Yes
Pre-Admission Testing	Yes	Yes
Durable Medical Equipment/Supplies	Yes	Yes
Home IV Infusion	Yes	Yes
Prosthetics/Orthotics	Yes	Yes
Home Health Care	Yes	Yes
Diabetic Education - Office	No	Yes
Diabetic Education – Outpatient and Facility	Yes (except for NIPSCO Represented Employees or Retirees)	Yes
Diabetic Supplies	Yes	Yes
TMJ	Yes	Yes
Hearing Exams	No	Yes
Ambulance	Yes	Yes
Maternity Services	Yes	Yes
Infertility Diagnosis	Yes	Yes

10.06 Special Co-Insurance Provisions.

(a) Preventive Health Services will be covered as follows:

(1) Covered Expenses for Preventive Health Services under the PPO Option will be paid at 100% of the Maximum Allowed Amount, with no Co-Payment or Deductible, if furnished In-Network. To the extent not prohibited by applicable law, Preventive Health Services furnished Out-of-Network will be subject to a Deductible and Co-Insurance.

(2) Covered Expenses for Preventive Health Services under the HD PPO Options will be paid at 100% of the Maximum Allowed Amount with no Co-Payment or Deductible.

(b) The following In-Network Covered Expenses will be paid at 80% of the Maximum Allowed Amount under the PPO Option after the applicable Co-Payment or Deductible is satisfied:

(1) Durable Medical Equipment and Supplies; and

(2) Prosthetics and Orthotics.

(c) The following Out-of-Network Covered Expenses will be paid at 80% of the Maximum Allowed Amount under the HD PPO Option after the applicable Deductible is satisfied:

(1) Hospital emergency room care services when care is associated with an accident, a medical emergency or a non-medical emergency; and

(2) Ambulance services (local ground or air transportation), when Medically Necessary to transport the Covered Person to the nearest appropriately equipped Hospital that is able to provide Medically Necessary treatment. Covered Expenses include air-ambulance services only if Medically Necessary.

10.07 Maximum Allowed Amount.

(a) General.

(1) With respect to those Covered Services for which claims are administered by Anthem Blue Cross/Blue Shield (hereinafter in this Section 10.07, the "Claims Administrator"), this Section 10.07 describes how the amount of reimbursement for Covered Services is determined.

(2) 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.

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

(A) to the extent the cost for such services, treatments and supplies are covered under the Plan and are not excluded;

(B) that are Medically Necessary; and

(C) that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

(4) A Participant will be required to pay all or a portion of the Maximum Allowed Amount to the extent such Participant has not met his or her Deductible or has a Co-payment or Co-insurance. In addition, when receiving Covered Services from an Out-of-Network Provider, a Participant will be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

When receiving 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. Such 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 the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not necessarily mean that the Covered Services received by a Covered Person were not Medically Necessary but, rather, may mean that the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or

reimbursement policies. For example, a 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.

(b) Provider Network Status.

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

(2) 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. A Participant may be asked to pay all or a portion of the Maximum Allowed Amount to the extent he or she has not met the applicable Deductible or to the extent there is a Co-payment or Co-insurance.

(3) 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.

(4) For Covered Services obtained 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:

(A) 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

(B) 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

(C) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (i) the complexity or severity of treatment; (ii) level of skill and experience required for the treatment; or (iii) comparable providers' fees and costs to deliver care; or

(D) 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

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

(5) 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 methods indicated in subsection (b)(4) above unless the contract between the Claims Administrator and that Provider specifies a different amount.

(6) Unlike In-Network Providers, Out-of-Network Providers may bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. The Participant is responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges.

(c) Prescription Drugs Obtained Through HD PPO Options. For prescription drugs obtained under an HD PPO Option, the Maximum Allowed Amount is the amount determined by the Claims Administrator using prescription drug cost information provided by the pharmacy benefits manager for that Option.

(d) Participant Cost Share.

(1) For certain Covered Services and depending on the Coverage Option, a Participant may be required to pay a part of the Maximum Allowed Amount as his or her cost share amount (for example, Deductible, Co-payment, and/or Co-insurance).

(2) A Participant's cost share amount and out-of-pocket limits may vary depending on whether services are obtained from an In-Network or Out-of-Network Provider.

(3) The Plan will not provide any reimbursement for non-Covered Services. A Participant will be responsible for the total amount billed by his or her 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 Plan and services received after benefits have been exhausted.

(e) 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 a Covered Person receives from an Out-of-Network Provider. In such circumstance, the Participant must contact the Claims Administrator in advance of the Covered Person's obtaining the Covered Service. The Plan also may authorize the In-

Network cost share amounts to apply to a claim for Covered Services if a Covered Person receives emergency services from an Out-of-Network Provider and is 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, the Participant will still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

(f) Covered Services Furnished by UPMC Providers. In-Network cost share amounts (for example, Deductible, Co-Payment and Co-Insurance) shall apply to claims for Covered Services that a Covered Person receives from a Provider (a "UPMC Provider") that the Claims Administrator determines is affiliated with the University of Pittsburgh Medical Center. Provided, however, that in certain circumstances determined by the Claims Administrator based upon its arrangement with UPMC Providers, a Participant will still be liable for the difference between the Maximum Allowed Amount and the UPMC Provider's charge.

ARTICLE XI
CONTRIBUTIONS TO THE PLAN

11.01 Employer Contributions. Except as provided in Article IV and subsection 22.05(f), each Employer will contribute to the cost of the Plan. The amount of the Employer contribution shall be determined by the Company or Plan Administrator on an annual basis or as otherwise required by a collective bargaining agreement.

11.02 Covered Person Contributions. As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company or Plan Administrator. The Covered Person contribution shall be the cost of the Plan less any Employer contribution described in Section 11.01.

ARTICLE XII
MANDATORY COST CONTAINMENT PROGRAM

12.01 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 shall be provided to each Covered Participant. Hospital admission pre-certification shall not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan other than this Article.

12.02 Pre-Certification Procedure. When a Physician recommends a non-Urgent Hospitalization, the Covered Participant or such Physician shall call the Pre-Certification Provider. The Covered Participant shall advise the Physician of the Plan's pre-admission certification requirement and provide such Physician with adequate information to obtain the pre-certification. The Covered Participant or Physician should secure pre-certification as soon as possible and before a Covered Person actually enters the hospital. It shall be the Covered Participant's responsibility to see that the Pre-Certification Provider is notified.

12.03 Urgent Hospital Admission. In the case of an Urgent Hospitalization, the Covered Person's Physician, the Hospital, or a family member shall telephone the Pre-Certification Provider within 48 hours of admission or on the first business day following weekend or holiday admissions. The Covered Participant shall provide the Pre-Certification Provider with the information requested by the Pre-Certification Provider.

12.04 Continued Stay Review. The Pre-Certification Provider may monitor all Hospital stays through contact with the Covered Person's Physician.

12.05 Other Required Pre-Certifications. The Covered Participant or Covered Participant's Physician shall notify the Pre-Certification Provider prior to the provision of the following additional services or supplies: (i) inpatient Surgery; (ii) a Newborn Child Hospital stay beyond that of the mother; (iii) plastic reconstructive surgery; and (iv) 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.

12.06 Penalty for Non-Compliance. If a Covered Participant fails to comply with the requirements of this Article, the Plan may assess a $300 penalty.

ARTICLE XIII
MEDICAL BENEFITS

13.01 General. Subject to the provisions of Articles VI, VII or X, as applicable, any Deductible requirements, and any limitations with respect to the Maximum Allowed Amount, medical benefits under the Plan shall include, but shall not be limited to, medical benefits set forth in this Article. Benefits under the HMO Option and the Other Insured Arrangement Option shall be set forth in the certificates of coverage, the group insurance policies, and any other applicable governing documents. 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. In addition, to the extent the 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). The following provisions shall apply to each of the PPO Option and the HD PPO Options, except as otherwise noted.

13.02 Preventive Care Benefit.

(a) General. The Plan shall cover Preventive Health Services. Covered Expenses shall include the Maximum Allowed Amount for services provided by a Physician for Preventive Health Services not associated with the diagnosis or treatment of a Sickness. No Co-Insurance, Co-Payment or Deductible shall be imposed with respect to Preventive Health Services under the HD PPO Options or with respect to Recommended Preventive Health Services or Additional Preventive Health Services under the PPO Option that are delivered by an In-Network Hospital, Physician or other provider. As described in Section 10.06, Co-Insurance, Co-Payments and/or Deductibles may apply under the PPO Option with respect to Additional Preventive Health Services and Recommended Preventive Health Services that are delivered by an Out-of-Network Hospital, Physician or other provider. For purposes of the Plan, diagnostic allergy testing and allergy injections, shots, serums and immunizations are not considered Preventive Health Services. Notwithstanding the foregoing, the Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a Recommended Preventive Health Service, to the extent not specified in the recommendation or guideline described in 29 C.F.R. §2590.715-2713(a)(1) or any successor regulation.

(b) Office Visits. 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 with respect to such 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 with respect to the office visit, unless the Recommended Preventive Health Services is furnished by an Out-of-Network Physician under the PPO Option. 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 with respect to such office visit.

13.03 Well Child Care. To the extent not already considered a Recommended Preventive Health Service, the Plan shall cover well child care. The provisions set forth in Articles VI or VII, as applicable, shall apply. Covered Expenses shall include charges associated with Physician office visits, routine medical examinations, immunizations and routine diagnostic procedures associated with routine medical examinations for children up to two years of age.

13.04 Maternity Benefits. The Plan shall provide maternity benefits for a Participant, for a Covered Participant's Spouse, Same-Sex Domestic Partner or female Dependent Child, and for a female Dependent Child of a Covered Same-Sex Domestic Partner, provided such persons are enrolled in the Plan. The provisions set forth in Articles VI or VII, as applicable, shall apply. Covered Expenses shall include charges associated with (a) pre-natal office visits, including one routine ultrasound, and (b) hospital maternity care related to a normal pregnancy and complications of pregnancy, including inpatient care and obstetrician services, and routine inpatient nursery charges (unlimited newborn visits), inpatient pediatrician visits and birthing center expenses while the mother is hospitalized after childbirth. If a Newborn Child requires treatment for an Sickness or Injury or remains hospitalized after the mother is discharged from the hospital after giving birth, benefits are provided under the Plan only if the Newborn Child is properly enrolled in the Plan. The Plan shall 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. Notwithstanding the foregoing, nothing shall preclude the mother's or newborns' attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable).

13.05 Convalescent Care Benefit.

(a) General. The Plan shall provide a convalescent care benefit. The provisions set forth in Articles VI or VII, as applicable, shall apply. Such convalescent care benefit shall provide benefits for expenses incurred during a convalescent care confinement after a Hospital stay that is covered under the Plan. To be covered, such confinement must start within 14 days of release from the Hospital and be ordered by the attending Physician as a result of the condition necessitating the prior hospitalization. Only charges incurred in connection with convalescence from the Sickness or Injury for which the Covered Person is confined shall be covered.

(b) Covered Expenses. If the requirements of subsection 13.05(a) are met, the Plan shall pay the Covered Expenses applicable to inpatient charges for the following services and supplies furnished while the Covered Person is under continuous care of the attending Physician and requires 24 hour care:

(1) Room and Board Charges and other services and supplies that are Medically Necessary;

(2) Use of special treatment rooms;

(3) X- ray and laboratory examinations;

(4) Physical, occupational, and speech therapy; and

(5) Oxygen, respiratory, and other gas therapy.

(c) Limitation. The convalescent care benefit shall be subject to limitations as contained in the Summary Plan Description.

13.06 Home Health Care. The Plan shall provide coverage for home health care as follows:

(a) PPO Option. The provisions set forth in Article VII shall apply. Up to 120 visits per calendar year for the services listed below as rendered by any Home Health Care Agency shall be Covered Expenses. Subject to the foregoing, the following, if ordered by a Physician and furnished to a Covered Person in his or her home for care in accordance with a home health care plan, shall be Covered Expenses:

(1) Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) if the services of a registered graduate nurse are not available;

(2) Part-time or intermittent home health aide services that consist primarily of caring for the individual;

(3) Physical, occupational, and speech therapy; and

(4) Medical supplies, drugs and medicines prescribed by a Physician, and laboratory or dietary services provided by or on behalf of a Hospital, but only to the extent that such items would have been covered under the Plan if the Covered Person had been hospitalized.

(b) HD PPO Options. The provisions set forth in Article VI shall apply. Up to 120 visits per calendar year for the services listed below as rendered by any Home Health Care Agency shall be Covered Expenses. Subject to the foregoing, the following, if the charge is made by a Home Health Care Agency and furnished to a Covered Person in his or her home for care in accordance with a home health care plan, shall be Covered Expenses:

(1) Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) if the services of a registered graduate nurse are not available;

(2) Part-time or intermittent home health aide services;

(3) Physical, occupational, and speech therapy; and

(4) Medical supplies, drugs and medicines prescribed by a Physician, and laboratory provided by a home health care agency, but only to the extent that such items would have been covered under the Plan if the Covered Person had been hospitalized.

13.07 Hospice Care Benefit.

(a) General. The Plan shall provide a Hospice Care Benefit. The provisions set forth in Articles VI or VII, as applicable, shall apply. Hospice care coverage provides benefits for charges incurred for treatment of a Terminally Ill person while in a Hospice Care Program. Such care may be administered through:

(1) A centrally administered, medically directed, and nurse coordinated program that; (1) provides a coherent system primarily of home care; (2) is available 24 hours a day, seven days a week; and (3) uses a Hospice Team; or

(2) Confinement in a Hospital.

With regard to benefits provided under the PPO Option, the Program shall meet applicable standards set by the National Hospice Organization and approved by the Claims Administrator. If such Program is required by a state to be licensed, certified, or registered, it shall also meet that requirement to be considered a Hospice Care Program eligible for coverage. With regard to benefits provided under the HD PPO Options, the Hospice Care Program must be licensed.

(b) Definitions. For purposes of this Section, the following terms have these meanings:

(1) "Counseling Services" means supporting services provided after the death of a Terminally Ill person, by members of a Hospice Team, in counseling sessions with the Family Unit. Counseling Services include care to (1) reduce or abate pain or other symptoms of mental or physical distress; and (2) meet the special needs arising out of the stresses of the Terminal Illness, death and bereavement.

(2) "Family Unit" means a Covered Participant and his or her other Dependents.

(3) "Hospice" means a free standing or Hospital affiliated facility that provides short periods of stay for the Terminally Ill in a home like setting for either direct care or respite. It must operate as an integral part of the Hospice Care Program.

(4) "Hospice Care Program" means a formal program directed by a Physician, as defined herein, to help care for a Terminally Ill Covered Person.

(5) "Hospice Services" means services and supplies furnished to a Terminally Ill person by a Hospice or a Hospice Team.

(6) "Hospice Team" means a group of professional and volunteer workers who provide care to reduce or abate pain or other symptoms of mental or physical distress and meet the special needs arising out of the stresses of the Terminal Illness, dying and bereavement. A Hospice Team shall include a Physician and a

registered nurse. It may also include social workers, clergy, counselors, volunteers, clinical psychologists, physiotherapists, and occupational therapists.

(7) "Remission" means a halt in the progression of the disease that led to the Terminal Illness or an actual reduction in the extent to which such disease has already progressed.

(8) "Terminally Ill" means the primary attending Physician, who is treating the Covered Person, has certified that such person's life expectancy is six months or less.

(c) Hospice Care Benefits.

The Plan shall cover any one period of care in a Hospice Care Program up to 180 days, including charges incurred for the Terminally Ill Covered Person (1) while not an inpatient in a Hospice for Hospice Services furnished under a Hospice Care Program; or (2) while an inpatient in a Hospice for Hospice Room and Board Charges and Hospice Services furnished under a Hospice Care Program.

(d) Counseling Services. Counseling Services are Covered Expenses under this Section.

(e) Conditions for Benefits.

As conditions of coverage under this Section, a Terminally Ill person shall (1) be in a Hospice Care Program; and (2) have the primary attending Physician furnish certification of the Terminally Ill status to the Claims Administrator. Additionally, the Hospice Services or stay shall be (1) provided while the individual is a Covered Person; (2) ordered by the supervising Physician who is directing the Hospice Care Program; (3) charged for by the Hospice Care Program; and (4) provided within six months of the individual's entry or re-entry (after a period of Remission) in the Hospice Care Program.

(f) Exclusions. The following shall not be covered under this Section:

(1) Charges incurred during a Remission period if the Covered Person is discharged from the Hospice Care Program during such period;

(2) Charges for services provided by a Relative;

(3) Charges for home-delivered meals or homemaker services;

(4) Charges for respite care;

(5) Charges for traditional medical services to treat the Terminal Illness, disease or condition; and

(6) Charges for transportation, including but not limited to ambulance transportation.

13.08 Elective Sterilization. Certain elective sterilization procedures such as tubal ligations and vasectomies shall be covered under the Plan. Such procedures shall be subject to the provisions set forth in Article VI or VII, as applicable. No reversal or attempted reversal of an elective sterilization shall be considered a Covered Expense. Only a Covered Participant's Spouse who is enrolled in the Plan shall be entitled to coverage under this Section.

13.09 Newborn Hospital Expenses. Hospital charges and professional services, including charges associated with circumcision, incurred by a Well Newborn Child during the initial period of hospital confinement, shall be covered as charges of the mother, provided the mother was covered for the Pregnancy.

Hospital charges and professional services incurred by a Newborn Child who is not a Well Newborn Child shall be considered charges of the Newborn Child, and providing the Newborn Child is a Covered Person, shall be covered pursuant to the provisions of the Plan.

13.10 Human Organ and Tissue Transplant Benefit.

(a) General. The Plan shall provide 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 expenses 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. The provisions set forth in Article VI or VII, as applicable, shall apply.

Notwithstanding the foregoing, the Plan shall pay benefits only for Hospital and Physician charges that are described elsewhere in the Plan as Covered Expenses. In order for such charges to be Covered Expenses, the Claims Administrator must approve all hospital confinements and/or surgical procedures related to an organ or tissue transplant. The benefits or requirements described below in this Section do not apply to Medically Necessary cornea or kidney transplants, which are paid as inpatient services, outpatient services or physician office services, depending where the service is performed. Without limiting the generality of any other provision of the Plan, benefits for charges of an Out-of-Network Hospital or Physician shall be limited to the Maximum Allowed Amount.

(b) Human Organ and Tissue Transplant Benefits. Without limiting the generality of the foregoing, the Plan shall pay benefits for the following Medically Necessary services related to a human organ or tissue transplants:

(1) Physician's charges related to surgery, including charges for a surgical physician's assistant (if Medically Necessary), and related anesthesia.

(2) Inpatient covered Hospital services related to the transplant procedure.

(3) 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).

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

(5) If a participating (In-Network) transplant facility performs transplant-related services, the Plan shall pay benefits for Medically Necessary pre-transplant evaluations and 12 months of transplant-related follow-up care (including any rejection events).

(6) The Plan shall provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when the Covered Person obtains prior approval and is required to travel more than 100 miles from his or her residence to reach the Hospital where the covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Hospital 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. Travel expenses and lodging expenses, on a combined basis, are limited to $20,000. To obtain reimbursement, the Covered Person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator.

13.11 Miscellaneous Covered Expenses. The Plan shall cover the miscellaneous services and supplies set forth below. Such coverage shall be subject to the provisions set forth herein, as applicable.

(a) Hospital inpatient expenses including:

(1) *Hospital Room and Board*. An amount per day up to the Semi-Private Room rate and charges incurred for use of the Intensive Care Unit (ICU) when ordered by the Covered Person's primary Physician. Care exceeding 23 hours shall be considered an inpatient admission and must be pre-certified pursuant to Article XII; and

(2) *Hospital Miscellaneous*. All other charges made by a Hospital during an inpatient confinement exclusive of personal items or services not necessary for the treatment of Sickness or Injury.

(b) Certain emergency care expenses including

(1) Hospital emergency room care services when care is associated with an accident, a medical emergency or a non-medical emergency;

(2) Urgent care services; and

(3) Ambulance services (local ground or air transportation), when Medically Necessary to transport the Covered Person to the nearest appropriately equipped Hospital that is able to provide Medically Necessary treatment. Covered Expenses include air-ambulance services only if Medically Necessary.

(c) Expenses in or out of the Hospital (unless otherwise specified), including:

(1) Hospital outpatient services: Services at an outpatient facility where care does not exceed 23 hours, but only if the charge for such service is less than an overnight charge in such outpatient care facility;

(2) Diagnostic x-ray and laboratory services;

(3) Surgical Procedure charges;

(4) Second surgical opinions, provided the Covered Person's Physician (other than the Physician offering the second surgical opinion) performs the eventual surgery;

(5) Anesthesia charges;

(6) Services related to mastectomies, including:

(A) All stages of reconstruction of the breast on which the mastectomy has been performed;

(B) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(C) Prostheses; and

(D) Treatment of physical complications of all stages of the mastectomy (including lymphedemas)

These services will be provided subject to the same Deductibles and Co-Insurance applicable to other medical and surgical benefits provided under the Plan.

(7) Physician and related services, including:

(A) Allergy injections, shots, serums and immunizations, unless otherwise limited by the Plan;

(B) Diagnostic allergy testing;

(C) If performed as a preventive care service or screening, one In-Network colonoscopy per Covered Person per calendar year, and one In-Network mammography per Covered Person per calendar year, which procedures shall not be subject to any 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;

(D) Radiation therapy;

(E) Infusion;

(F) Pathological services;

(G) Electrocardiograms;

(H) Cardiac rehabilitation;

(I) Inpatient physical medicine/rehabilitation, limited to 60 days per Covered Person per year;

(J) Outpatient Physical therapy (up to 26 visits per calendar year). With regard to benefits provided under the HD PPO Options, this 26-visit limit includes visits for occupational therapy. Services must be provided by a registered professional physical therapist who renders the appropriate services under the supervision of a Physician;

(K) Electroencephalograms;

(L) Hospital visits;

(M) Assistant surgeon charges (when Medically Necessary);

(N) Private duty nursing services (except those provided by a Relative);

(O) Medically Necessary durable medical equipment and supplies including

(i) Rental of wheelchairs, hospital beds, equipment for the administration of oxygen, and iron lungs and other mechanical equipment to treat respiratory paralysis;

(ii) Internal cardiac valves and internal pacemakers;

(iii) Mandibular reconstruction devices that are not primarily used to support a dental prosthesis; and

(iv) Bone screws, bolts, nails, plates, and other internal and permanent devices that are approved by the Plan Administrator or Claims Administrator.

(P) Medical and surgical dressings, supplies, casts, splints, trusses, orthopedic braces, crutches, and prosthetic devices;

(Q) Hearing care examinations for Sickness or Injury or to determine the need for a hearing aid – each Covered Person is limited to 1 exam and 1 aid per ear during a two-calendar year period, with no lifetime maximum;

(R) Vision examinations for Sickness or Injury;

(S) Wigs – each Covered Person shall be eligible for one wig per Plan Year when baldness is a result of chemotherapy, alopecia, radiation therapy or surgery;

(T) Blood and blood related products;

(U) Oxygen and its administration;

(V) Respiratory therapy;

(W) Chemotherapy for treatment of a malignancy;

(X) Hemodialysis when provided to a Covered Person as an inpatient of a Hospital or as an outpatient in a Medicare approved dialysis center;

(Y) Speech therapy, but only to restore speech abilities lost due to Sickness or Injury or surgery on account of a Sickness (other than a functional nervous disorder) (up to 26 visits per calendar year; additional visits may be authorized based upon a determination by the Claims Administrator that such visits are Medically Necessary). 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 the therapy must be designed to provide significant improvement on a relatively short-term basis. Services must be provided by a registered professional speech therapist certified by the American Speech and Hearing Association who renders the appropriate services under the supervision of a Physician;

(Z) Occupational therapy (up to 26 visits per calendar year). Services must be provided by a registered professional physical therapist who renders the appropriate services under the supervision of a Physician. With regard to benefits provided under the HD PPO Options, this 26-visit limit includes visits for Physical therapy;

(AA) Chiropractic care when provided by a licensed chiropractor to a Covered Person on an out-patient basis (up to 26 visits per calendar year);

(BB) Dental services provided by a dentist, oral surgeon, or Physician only as follows:

(i) Treatment for Injury to natural teeth or facial bones within 36 months of such Injury;

(ii) Extraction of completely bony impacted teeth, including completely impacted wisdom teeth; and

(iii) Services in connection with a gingivectomy (PPO Option only).

(CC) Diagnosis of infertility;

(DD) Home IV;

(EE) Blood glucose testing machines;

(FF) Diabetic education and, for the HD PPO Option only, diabetic supplies that are not available over the counter, if prescribed by a Physician for a medical condition or diagnosis; and

(GG) Appliances and Medically Necessary surgical procedures to treat temporomandibular joint dysfunction.

(d) Expenses out of the Hospital, including:

(1) Physician office visits;

(2) Doctor's office surgery; and

(3) Skilled nursing facility charges, but excluding charges for custodial care, domiciliary care and care attributable primarily to mental retardation, senile deterioration or mental deficiency.

13.12 Alternate Treatment Under Case Management. In cases where a Covered Person's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator, following consultation with appropriate medical professionals, shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of the patient's care.

13.13 Payment of Benefits. All benefits shall be paid directly to the provider unless the Covered Participant submits proof that the bill has been paid or if services are received Out-of-Network, in which case benefits shall be paid to the Covered Participant, or if deceased, in accordance with Section 13.13. Benefits may be paid directly from the general assets of the Employers or from any other lawful funding vehicle as may be established by the Company.

13.14 Designation of Beneficiaries. Each Covered Person, from time to time, may name any person (who may be named concurrently, contingently or successively) to whom the Covered Person's benefits under the Plan are to be paid if the Covered Person dies before he or she receives all of such benefits. Each such beneficiary designation will revoke all prior designations by the Covered Person, shall not require the consent of any previously named beneficiary, shall be in a form prescribed by the Plan Administrator, and shall be effective only when filed with the Plan Administrator during the Covered Person's lifetime. If a Covered Person fails to designate a beneficiary before his or her death, as provided above, or if the designated beneficiary dies before the date of the Covered Person's death or before complete payment of the Covered Person's benefits, the Plan Administrator shall pay such benefits to the Covered Person's Spouse; or if no Spouse is living, to his or her lawful descendants, *per stirpes*; or if none are living, to the legal representative of the estate of the Covered Person; or if none is appointed within 6 months after the date of his or her death, to his or her heirs under the laws of the state in which he or she is domiciled at the date of his or her death.

13.15 Facility of Payment. When a person entitled to benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the Plan.

ARTICLE XIV
PRESCRIPTION DRUG COVERAGE

14.01 General. The Plan provides prescription drug coverage in accordance with the provisions in this Article. A prescription drug card shall be issued to each Covered Person which shall provide coverage as set forth in the remainder of this Section.

14.02 Deductible.

(a) With regard to the HD PPO Options, no prescription drug benefits are payable under the Plan until the Employee, or the Employee and his or her Family, as applicable, have satisfied the annual Deductible as described in Section 10.01.

(b) With regard to the PPO Option, no Deductible shall apply to items covered under this Article.

14.03 Co-Payments and Co-Insurance.

(a) PPO Option. The amount of prescription drug Co-Payment depends on the category of drug the Covered Participant purchases. There is an out-of-pocket expense limitation with respect to prescription drugs of $1,500 per person per calendar year and (A) for Covered Participants other than (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees, $8,700 per family per calendar year, and (B) for Covered Participants who are (i) NIPSCO Represented Employees or (ii) Retirees who were former NIPSCO Represented Employees, $9,300 per family per calendar year.

(1) *Participating Retail Pharmacy.* For a 30-day supply, a Covered Participant shall pay 20 percent of the cost of the drug, subject to a minimum and maximum cost, as set forth in the table below.

30-Day Supply	Co-Payment	Minimum	Maximum
Generic	20% of the drug cost	$5	$15
Formulary	20% of the drug cost	$15	$45
Non-formulary	20% of the drug cost	$30	$90

(2) *Mail Order.* The Co-Payment for a prescription drug ordered through the mail-order service shall be based on the coverage class of the drug.

Co-Payments applicable to Covered Participants other than (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees:

90-Day Supply	Co-Payment	Covered Amount
Generic	$20	100% after Co-Payment
Formulary	$60	100% after Co-Payment
Non-formulary	$120	100% after Co-Payment

Co-Payments applicable to (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees:

90-Day Supply	Co-Payment	Covered Amount
Generic	$10	100% after Co-Payment
Formulary	$30	100% after Co-Payment
Non-formulary	$60	100% after Co-Payment

(3) *Ninety-Day Supply at Retail Program.* Covered Participants may purchase a 90-day supply of prescription drugs from a participating retail pharmacy under the

Ninety-Day Supply at Retail Program. The Co-Payment for such 90-day supply shall be 20 percent of the drug cost, subject to a minimum and maximum cost, as set forth in the table below.

90-Day Supply	Co-Payment	Minimum	Maximum
Generic	20% of the drug cost	$15	$45
Formulary	20% of the drug cost	$30	$90
Non-formulary	20% of the drug cost	$60	$180

(b) HD PPO Options. The amount of Co-Insurance depends on the source of the prescription drugs. No prescription drug benefits are payable under the Plan until the Employee, or the Employee and his or her Family, as applicable, have satisfied the annual Deductible as described in Section 10.01.

Source	Covered Amount	Co-Insurance
Retail (30-day supply)	80%	20%
Mail Order (90-day supply)	80%	20%
Out-of-Network	60%	40%

14.04 Definitions. For purposes of this Section, the following definitions shall apply:

(a) "Generic" means drugs no longer covered by the original patent.

(b) "Formulary" means a list of approved drugs covered under the prescription drug plan.

(c) "Non-formulary" means drugs not chosen for the Formulary, which do not qualify as Generic.

14.05 Items Covered. Items covered under this Section include, without limitation, the following Federal legend drugs and supplies, but excluding any item described in Section 14.06 below:

(a) Insulin;

(b) Disposable insulin needles/syringes;

(c) AZT (Retrovir);

(d) Fluoride vitamins to age 19;

(e) Immunosuppressants;

(f) Injectables, other than insulin;

(g) Vitamins (only if prescribed);

(h) 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 (provided, however, that prescription contraceptive drugs and contraceptive devices for women will be covered as a Recommended Preventive Health Service with no co-pays or deductibles; provided, further, that if a Covered Person requests that a brand-name contraceptive drug be dispensed when a generic equivalent is available that is medically appropriate, the

Covered Person will be required to pay the regular co-payment, in the case of the PPO Option, or the applicable deductible, in the case of an HD PPO Option);

(i) Retin-A, up to age 25;

(j) Diabetic diagnostics;

(k) Certain smoking cessation products;

(l) Compound medications of which at least one ingredient is a Federal legend drug; and

(m) Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

14.06 Items Not Covered. Items not covered under this Section include, without limitation, the following, in addition to other items that the Plan Administrator determines from time to time are not eligible for coverage:

(a) Drugs or medicines that are lawfully obtainable without the prescription of a Physician, whether or not such drugs are actually obtained by prescription;

(b) Prescription drugs dispensed through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the Plan's pharmacy benefit manager;

(c) Drugs prescribed for cosmetic reasons;

(d) Drugs used for the treatment of infertility or relating to conception;

(e) Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological;

(f) Hair treatments;

(g) Anti-wrinkle treatment;

(h) Blood glucose testing machines;

(i) Vaccines, serums and allergens;

(j) Nutritional dietary supplements;

(k) Over-the-counter medications; and

(l) Any item that is not legally procured, including without limitation any Federal legend drug that may not legally be imported from another county.

14.07 Preauthorization. The Plan may require authorization before it will cover certain drugs. Such authorization shall be requested and granted pursuant to procedures as the Plan may establish.

14.08 Step-Therapy. Except with respect to PPO Option coverage for Represented Employees and Retirees who were former Represented Employees (for whom step therapy shall not apply), coverage under the Plan shall be subject to a step-therapy prescription drug program that requires

pre-approval of certain prescription drugs. Under the terms of such program, a Covered Person shall consult his or her Physician about clinically effective and less costly prescription drug alternatives before the Plan will consider approval of the use of the drugs on the step therapy list.

14.09 Brand versus Generic Drugs. Except with respect to PPO Option coverage for Represented Employees and Retirees who were former Represented Employees, if a prescribed brand-name drug has a Generic substitute and a Covered Person requests that the brand-name drug be dispensed, the Covered Participant 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. With respect to PPO Option coverage for Represented Employees and Retirees who were former Represented Employees, if a Generic substitute is prescribed and a Covered Person requests that the brand-name drug be dispensed, the Covered Participant 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.

ARTICLE XV
MENTAL ILLNESS COVERAGE

15.01 General. The Plan shall provide benefits for treatment related to mental disorders and substance use disorders as set forth in the applicable Summary Plan Description. Coverage of such treatment shall be subject to the provisions set forth herein.

15.02 Coverage. Coverage shall be subject to the following conditions and limitations:

(a) PPO Option.

(1) Benefits for mental disorders shall be available as follows:

For Covered Participants other than (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees:

Category	Covered Amount	Co-Payment
Inpatient – In-Network	80% after Deductible	N/A
Inpatient – Out-of-Network	60% after Deductible	N/A
Outpatient – In-Network	100%	$30
Outpatient – Out-of-Network	60% after Deductible	N/A

For (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees:

Category	Covered Amount	Co-Payment
Inpatient – In-Network	85% after Deductible	N/A
Inpatient – Out-of-Network	65% after Deductible	N/A
Outpatient – In-Network	100%	$15
Outpatient – Out-of-Network	65% after Deductible	N/A

(2) Benefits for substance abuse treatment shall be available as follows:

For Covered Participants other than (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees:

Category	Covered Amount	Co-Payment
Detox Inpatient – In-Network	80% after Deductible	N/A
Detox Inpatient – Out-of-Network	60% after Deductible	N/A
Detox Outpatient – In-Network	100%	$30
Detox Outpatient – Out-of-Network	60% after Deductible	N/A
Rehab Inpatient – In-Network	80% after Deductible	N/A
Rehab Inpatient – Out-of-Network	60% after Deductible	N/A
Rehab Outpatient – In-Network	100%	$30
Rehab Outpatient – Out-of-Network	60% after Deductible	N/A

For (i) NIPSCO Represented Employees and (ii) Retirees who were former NIPSCO Represented Employees:

Category	Covered Amount	Co-Payment
Detox Inpatient – In-Network	85% after Deductible	N/A
Detox Inpatient – Out-of-Network	65% after Deductible	N/A
Detox Outpatient – In-Network	100%	$15
Detox Outpatient – Out-of-Network	65% after Deductible	N/A
Rehab Inpatient – In-Network	85% after Deductible	N/A
Rehab Inpatient – Out-of-Network	65% after Deductible	N/A
Rehab Outpatient – In-Network	100%	$15
Rehab Outpatient – Out-of-Network	65% after Deductible	N/A

(b) HD PPO Options.

(1) Benefits for mental disorders shall be available as follows:

Category	HD PPO 1 Covered Amount*	HD PPO 2 Covered Amount*
Inpatient – In-Network	80%	80%
Inpatient – Out-of-Network	60%	60%
Outpatient – In-Network	80%	80%
Outpatient – Out-of-Network	60%	60%

* After Deductible

(2) Benefits for chemical dependency shall be available as follows:

Category	HD PPO 1 Covered Amount*	HD PPO 2 Covered Amount*
Inpatient – In-Network	80%	80%
Inpatient – Out-of-Network	60%	60%
Outpatient – In-Network	80%	80%
Outpatient – Out-of-Network	60%	60%

* After Deductible

ARTICLE XVI
EMPLOYEE ASSISTANCE PROGRAM COVERAGE

16.01 Benefits. Covered Persons may choose to receive Employee Assistance Program benefits for which they are eligible as set forth in the applicable Summary Plan Description.

16.02 Claim for Benefits. Any Covered Person, or his or her duly authorized representative, may file a claim in accordance with the procedures set forth in the applicable Summary Plan Description for the benefits offered hereunder to which the claimant believes he or she is entitled, but that have been previously denied by the Plan Administrator.

ARTICLE XVII
GENERAL EXCLUSIONS

17.01 Services or Supplies not Covered under PPO Option. Notwithstanding any other Plan provision, the Plan shall not provide coverage under the PPO Option for services or supplies:

(a) Which are determined not Medically Necessary;

(b) Received from an individual or entity that is not a Provider, as defined in the Plan;

(c) Which are Experimental or Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental or Investigational service or supply, as determined by the Claims Administrator, on behalf of the Employer. 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;

(d) For any condition, disease, defect, aliment, or Injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if the Covered Person receives the benefits in whole or in part. This exclusion also applies whether or not the Covered Person claims the benefits or compensation. It also applies whether or not the Covered Person recovers from any third party;

(e) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation;

(f) For Sickness or Injury that occurs as a result of any act of war, declared or undeclared;

(g) For a condition resulting from direct participation in a riot, civil disobedience;

(h) For court ordered testing or care;

(i) For which you have no legal obligation to pay in the absence of this or like coverage;

(j) 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;

(k) Prescribed, ordered, or referred by, or received from a member of the Covered Person's immediate family, including the Covered Person's Spouse, Child, brother, sister, parent, or self;

(l) For completion of claim forms or charges for medical records or reports unless otherwise required by law;

(m) For missed or canceled appointments;

(n) For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;

(o) For which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a Covered Person had applied for Part A and/or Part B, except, as specified elsewhere in the Plan or as otherwise prohibited by federal law;

(p) The cost of which is in excess of the Maximum Allowed Amount;

(q) Incurred prior to the effective date of coverage;

(r) Incurred after the termination date of this coverage except as specified elsewhere in the Plan;

(s) For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve a Covered Person's appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of a Covered Person's skin or to change the size, shape or appearance of facial or body features (such as a Covered Person's nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law;

(t) For custodial care, domiciliary or convalescent care, except as otherwise provided in the Plan;

(u) For foot care only to improve comfort or appearance;

(v) For any treatment of teeth, gums or tooth related service except as otherwise specified as covered in the Plan;

(w) Related to weight loss or treatment of obesity, except for surgical treatment of morbid obesity;

(x) For sex transformation surgery and related services, or the reversal thereof;

(y) For marital counseling;

(z) For eyeglasses or contact lenses except for the first pair of eyeglasses or contact lenses prescribed following cataract surgery;

(aa) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein;

(bb) For reversal of sterilization;

(cc) For artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of infertility;

(dd) For or related to developmental delays, autistic disease, learning disabilities, hyperkinetic syndromes, or mental retardation (except for prescription drugs as provided in Article XIV);

(ee) For personal hygiene and convenience items;

(ff) For care received in an emergency room which is not emergency care, except as specified in the Plan;

(gg) For expenses incurred at a health spa or similar facility;

(hh) For self-help training and other forms of non-medical self care, except as otherwise provided herein;

(ii) For examinations relating to research screenings;

(jj) For stand-by charges of a Physician;

(kk) For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, for marriage or for other purposes;

(ll) Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;

(mm) Related to any mechanical equipment, device, or organ. However, this exclusion does not apply to a left ventricular assist device when used as a bridge to a heart transplant. Permanent LVADs are now approved by the FDA and the Claims Administrator will allow based on medical review for particular circumstances;

(nn) For private duty nursing services except when provided through the Home Health Care services benefit;

(oo) Related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing;

(pp) For (or related to) any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not

limited to pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology;

(qq) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, 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;

(rr) Consisting of drugs in quantities which exceed the limits established by the Plan;

(ss) For elective abortions;

(tt) For developmental delays;

(uu) For care that is considered to be maintenance in nature, unless Medically Necessary;

(vv) For care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease;

(ww) For speech therapy, unless therapy is expected to restore speech to a person who has lost speech function as a result of disease or Injury;

(xx) For which a charge is made, or which are furnished, only because there is health care;

(yy) For dental work other than when related to an accident;

(zz) The cost of which is in excess of a negotiated rate or reimbursement as specified in any agreement between the Claims Administrator and a preferred provider; and

(aaa) For non-accident oral surgery.

17.02 Services, Supplies and Charges not Covered under HD PPO Options. Notwithstanding any other Plan provision, the Plan shall not provide coverage under the HD PPO Options for any of the following services, supplies or charges:

(a) 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 military service provided or available from the Veterans' Administration or military facilities as required by law;

(b) Services for custodial care;

(c) Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care;

(d) 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:

(e) Charges for treatment received before coverage under this Option began or after it is terminated;

(f) 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;

(g) 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;

(h) 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;

(i) 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);

(j) 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;

(k) 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. 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;

(l) Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory program;

(m) Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan;

(n) Services for prescription and non-prescription medications unless provided by a Hospital in conjunction with admission;

(o) 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;

(p) 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;

(q) Vitamins, minerals and food supplement, 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;

(r) Services for Hospital confinement primarily for diagnostic studies;

(s) 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;

(t) Donor search/compatibility fee (except as otherwise indicated in the Plan);

(u) Hearing aids, hearing devices or examinations for prescribing or fitting them;

(v) Contraceptive drugs, except for any contraceptive drugs expressly covered by the Plan, and except as otherwise required by law;

(w) In-vitro Fertilization and artificial insemination;

(x) Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or prescriptions or medications related to hair growth;

(y) Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided as a Covered Service under the Plan;

(z) Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy;

(aa) Services of a Christian Science Practitioner;

(bb) Certain Services and supplies for smoking cessation programs and treatment of nicotine addiction;

(cc) Services provided in a halfway house for substance abuse rehabilitation;

(dd) 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;

(ee) Contraceptive devices, except for any contraceptive devices expressly covered by the Plan, and except as otherwise required by law;

(ff) Elective abortions;

(gg) 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;

(hh) Any treatment of teeth, gums or tooth related service except as otherwise specified as covered;

(ii) 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;

(jj) Examinations relating to research screenings;

(kk) Foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails;

(ll) Mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer;

(mm) Stand-by charges of a Physician;

(nn) Routine care is not covered, except for Preventive Health Services expressly provided for by the Plan;

(oo) Biofeedback;

(pp) Services or supplies provided by a member of a Covered Person's family or household;

(qq) Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator;

(rr) Fees or charges made by an individual, agency or facility operating beyond the scope of its license;

(ss) 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;

(tt) Services for any form of telecommunication;

(uu) 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 provider their 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;

(vv) Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available;

(ww) 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;

(xx) Charges for or related to sex change surgery or to any treatment of gender identity disorders;

(yy) Reversal of vasectomy or tubal ligation;

(zz) 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;

(aaa) 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;

(bbb) 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;

(ccc) 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

(ddd) 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):

ARTICLE XVIII
SUBROGATION

18.01 Subrogation. If an Other Party is liable or legally responsible to pay expenses, compensation and/or damages in relation to a Sickness or an Injury incurred by any Covered Person, and benefits are payable under the Plan in relation to such Sickness or Injury, the Plan shall be subrogated to all rights of recovery of such Covered Person. The Covered Person or his or her legal representative shall transfer to the Plan any rights he or she may have to take legal action arising from the Sickness or Injury so that the Plan may recover any sums paid on behalf of the Covered Person. If the Covered Person fails to take legal action against an Other Party, and the Plan elects to take such legal action against such Other Party, in addition to the right to recover Plan benefits paid, the Plan shall be entitled to all expenses, including reasonable attorney's fees, incurred for such recovery. If the Plan recovers an amount greater than Plan benefits paid, the excess, reduced by the expenses of recovery, including reasonable attorney's fees, shall be paid to the Covered Person. The Plan shall have the right, with prior notice to, but without the consent of, the Covered Person, to compromise the amount of its claim if, in the opinion of the Plan Administrator, it is appropriate to do so.

18.02 Right of Recovery. The Plan may recover from a Covered Person or his or her legal representative the amount of any benefits paid under the Plan from any payment the Covered Person receives or is entitled to receive from an Other Party. The Plan shall not be responsible for any attorney's fees associated with any payment received by a Covered Person, unless the Plan expressly assumes such obligation prior to the Covered Person's recovery. Accordingly, unless the Plan expressly agrees otherwise, its recovery shall not be offset by any attorney's fees incurred by a Covered Person.

18.03 Application to Funds Recovered. For the avoidance of doubt, the Plan's right of subrogation described in Section 18.01 and its right of recovery described in Section 18.02 apply to any funds recovered from an Other Party by or on behalf an Employee or Retiree, an Employee's or 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 the provisions of Sections 18.01 and 18.02, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

18.04 Cooperation Required. The Covered Person or his or her legal representative shall cooperate fully with the Plan in asserting its subrogation and recovery rights. The Covered Person or his or her legal representative shall, upon request from the Plan, provide all information and sign and return all documents or agreements deemed by the Plan Administrator to be necessary for the Plan to exercise its rights under this Article. No Covered Person shall take any action to prejudice the Plan's subrogation rights. Each Covered Person shall provide notice to the Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. As a condition of participating in the Plan, each Covered Person acknowledges that the Plan has a right to intervene in any lawsuit involving an Other Party, and such Covered Person consents to the unfettered exercise of that right. Failure or refusal to execute any of the aforementioned documents or agreements or to furnish information, to comply with the obligations under such agreements or to cooperate fully with the Plan in asserting its subrogation and recovery rights does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

18.05 First Lien Created. The Plan shall have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or any other means, that the Covered Person receives or is entitled to receive from any Other Party. 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 Plan. Such lien shall not exceed the lesser of:

(a) The amount of benefits paid by the Plan for the Sickness or Injury, plus the amount of all future benefits that may become payable under the Plan that result from the Sickness or Injury. The Plan shall have the right to offset or recover such future benefits from the amount received from the Other Party; or

(b) The amount recovered from the Other Party.

The Plan's first lien rights will not be reduced (1) due to the Covered Person's own negligence; (2) due to the Covered Person not being made whole; or (3) due to any attorney's fees and costs incurred by the Covered Person. Without limiting the generality of the foregoing, neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Plan, and as a condition of participating in the Plan, each 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.

18.06 Constructive 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 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 Plan in accordance with this Article, and that such funds shall be held in a constructive trust until distributed in accordance with this Article.

18.07 Personal Liability Created. If a Covered Person or his or her legal representative makes any recovery from any Other Party and fails to reimburse the Plan for any benefits paid as a result of the Sickness or Injury, then (1) the Covered Person or his or her legal representative shall be personally liable to the Plan for the amount of the benefits paid under the Plan; and (2) the Plan may reduce future benefits payable by the amount of payment that the Covered Person or his or her legal representative has received from the Other Party. If the Plan institutes legal action against a Covered Person who fails to reimburse the Plan as required by this Section, in addition to liability to the Plan for the amount of benefits paid under the Plan, such Covered Person shall be liable to the Plan for the amount of the Plan's costs of collection, including reasonable attorney's fees.

ARTICLE XIX
NONDUPLICATION OF BENEFITS

19.01 General. Nonduplication of Benefits rules set forth the order of payment of Covered Expenses when two or more plans, including Medicare, are liable for payment. This Article shall not apply to benefits obtained by a Covered Person from an individual medical insurance policy under which such Covered Person is entitled to benefits as a named person.

19.02 Definitions. For purposes of this Article, the following definitions shall apply:

(a) "Allowable Expense" shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made.

(b) "Plan" or "Benefit Plan" means this Plan or any one of the following plans:

(1) Group or blanket benefit plans, including health maintenance organizations;

(2) Blue Cross and Blue Shield group plans;

(3) Group practice and other group prepayment plans;

(4) Federal government plans or programs, including Medicare;

(5) Other plans required or provided by law; and

(6) "No fault vehicle insurance," by whatever name it is called, when inclusion is not prohibited by law.

"Plan" or "Benefit Plan" shall not encompass Medicaid or any other plan, program, policy or arrangement that, by its terms, does not allow coordination, integration or carve out of benefits.

(c) "Order of Benefits Determination" shall mean the method for ascertaining the order in which the Plan renders payment hereunder.

19.03 Application of the Rules. The Plan that is obligated to pay its benefits first shall be known as the "Primary" Plan. The Plan that, by its terms, is obligated to pay additional benefits for Allowable Expenses not paid by the Primary Plan is known as the "Secondary" Plan. Where another Plan contains a provision providing for coordination, integration or carve out of benefits, the following Order of Benefits Determination shall establish the responsibility for payment hereunder:

(a) The Plan covering the patient as an employee shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the patient as a Dependent.

(b) The Plan covering the patient as a Dependent of a person with a birthday earlier in the year shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the patient as a Dependent of a person with a birthday later in the year. In the event of divorce or legal separation, the following order shall establish responsibility for payment.

(1) If a court decree has determined financial responsibility for a Child's health care expenses, the Plan of the parent having that responsibility is Primary. If the parent with financial responsibility has no coverage for the Child's health care expenses, but that parent's Spouse does, such Spouse's Plan is Primary.

(2) The Plan of the parent with custody of the Child pays before the Plan of the other parent or the Plan of any stepparent.

(3) The Plan of the stepparent married to the parent with custody of the Child pays first.

(4) The Plan of the parent without custody of the child pays before the non-custodial stepparent.

If this Order of Benefits Determination is not recognized by the other Plan, the order will be determined at the option of the Claims Administrator on a case by case basis.

(c) Where the order of payment cannot be determined in accordance with (a) and (b) above, the Primary Plan shall be deemed to be the Plan that has covered the patient for the longer period of time.

19.04 Plan As Primary Payor. If this Plan is Primary, it will provide payment in accordance with its terms.

19.05 Plan As Secondary Payor. If this Plan is Secondary, it will provide payment in accordance with its terms, considering as a Covered Expense the amount that would have been a Covered Expense in the absence of the Primary Plan, less the amount payable from the Primary Plan.

19.06 When Other Plan Has No Nonduplication of Benefits Rules. This Plan shall be considered to be Secondary when the other Plan does not contain a coordination, integration or carve-out of benefits provision, or if the other Plan provides that it will be Secondary payor in all instances.

19.07 Vehicle Coverage Limitation. When medical benefits are available under vehicle insurance, this Plan shall always be considered as Secondary regardless of the individual's election under PIP (personal injury protection) coverage with the vehicle insurance carrier.

19.08 If Medicare Is Involved.

(a) General. Notwithstanding anything in the Plan to the contrary, the provisions of this Section apply if Medicare is involved. Medicare shall be deemed to be "involved" if any Covered Person is eligible for benefits from Medicare, regardless of whether such Person has enrolled for coverage under Medicare. A Medicare-eligible Covered Person who fails to enroll for Medicare coverage shall be deemed to be enrolled under all parts of Medicare except Medicare Part D.

(b) Definitions. The following terms have the meanings set forth herein for purposes of this Section:

(1) "Benefits" means any service or supply for which a Medicare Advantage Organization incurs a liability under a Medicare Advantage plan.

(2) "Current Employment Status" has the meaning given such term in 42 C.F.R. § 411.104, or in any successor regulation or provision implementing the Medicare Secondary Payer Rule, 42 U.S.C. § 1395y(b)(1).

(3) "Medicare Advantage Plan Enrollee" means a Medicare Advantage eligible individual who has enrolled in a Medicare Advantage Plan.

(4) "Medicare Advantage Organization" means a public or private entity organized and licensed by a State as a risk bearing entity (with the exception of provider sponsored organizations receiving waivers) that is certified by the Centers for Medicare and Medicaid Services ("CMS") as meeting the requirements for participation in the Medicare Advantage program.

(5) "Medicare Advantage Plan" means health benefits coverage offered under a policy or contract by a Medicare Advantage Organization.

(6) "Medicare Advantage Provider" means any provider authorized to provide medical services or supplies under the Medicare Advantage program.

(7) "Medicare Advantage Provider Network" means the Medicare Advantage Providers with which a Medicare Advantage Organization contracts or makes arrangements to furnish covered health care services to Medicare Advantage Plan Enrollees.

(8) "Medicare" means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as amended.

(9) "Order of Benefits Determination" means the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

(10) "Person" means a person who is eligible for benefits as a Covered Person under this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

(c) Order of Benefits Determination. When Medicare is involved, the Order of Benefits Determination shall be as follows:

(1) For Employees who are Covered Persons with Current Employment Status, and for their Dependents who are Covered Persons, this Plan will be Primary payor and Medicare will be Secondary payor.

(2) For Covered Persons who are not in Current Employment Status and who are eligible for Medicare by reason of age alone, and for their Dependents who are Covered Persons and eligible for Medicare, this Plan will be Secondary payor and Medicare will be Primary payor.

(3) For a Post-65 Retiree Plan Participant's Dependent who is a Covered Person, this Plan will be Secondary payor and Medicare will be Primary payor.

(4) For Covered Persons eligible for Medicare, either entirely or in part, by reason other than age, the following provisions shall apply:

(A) For persons eligible for Medicare by reason of disability, the following provisions shall apply:

(i) For Employees who are not actively working and have received disability benefits from an Employer for more than six months, and for their Dependents, this Plan will be Secondary payor and Medicare will be Primary payor.

(ii) For Employees or Retirees who are not actively working and have COBRA continuation coverage or who are otherwise not in Current Employment Status, and for their Dependents, this Plan will be Secondary payor and Medicare will be Primary payor.

(B) Subject to subparagraph (C) below, for a Covered Person eligible for Medicare by reason of end-stage renal disease, benefits of this Plan shall be Primary during the initial thirty-month period that begins on the date such Covered Person first becomes eligible for Medicare due to end-stage renal disease. Once the thirty-month period has expired, Medicare shall be Primary.

(C) For a Covered Person eligible for Medicare by reason of end-stage renal disease and for whom Medicare was already Primary at the time such Covered Person became eligible for Medicare due to end-stage renal disease, benefits of this Plan shall continue to be Secondary and Medicare shall be Primary. Provided, however, that Medicare must have been Primary at the time the Covered Person became eligible for Medicare due to end-stage renal disease because all of the following are true: (i) the Covered Person was already entitled to Medicare on the basis of age or disability; (ii) the Covered Person did not have coverage under the Plan by virtue of his or her own Current Employment Status or the Current Employment Status of another Covered Person; and (iii) the Plan was Secondary because it had justifiably taken into account the age-based or disability based Medicare entitlement of the Covered Person.

(5) For Covered Persons who are Medicare Advantage Plan Enrollees, this Plan shall be either a Primary or Secondary payor in accordance with subparagraphs (1) through (4) above.

(d) Payment Provisions. If this Plan is Secondary to Medicare, this Plan will provide payment in accordance with its terms, considering as a Covered Expense the amount that would have been a Covered Expense in the absence of Medicare, less (1) the amount payable from Medicare; and (2) the amount denied by Medicare for which a Covered Person is not legally responsible. An amount shall be deemed "payable" from or "denied" by Medicare without regard for whether the person is enrolled under Medicare. If a Medicare Advantage Plan Enrollee who is a Covered Person receives services or supplies for which no Benefits are payable because such services or supplies are from a provider that is not a Medicare Advantage Provider, or are provided outside of a Medicare Advantage Provider Network, this Plan, if a Secondary payor, shall provide benefits in the same amount as if the Covered Person had received Benefits.

(e) Coordination of Medicare Part D. If a Covered Person has prescription drug coverage under the Plan and Medicare Part D simultaneously, such coverage shall coordinate as provided by law.

ARTICLE XX
ADMINISTRATION OF PLAN

20.01 Committee to Administer the Plan. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA.

20.02 The Committee. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

20.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Plan;

(h) To determine the status and rights of all Covered Persons;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Plan;

(k) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Plan;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

20.04 Interpretative Authority. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Summary Plan Description thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

20.05 Appointment of the Claims Administrator. The Plan Administrator shall appoint a Claims Administrator to provide administrative services to the Plan Administrator in connection with the operation of the Plan and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons or entity serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

ARTICLE XXI
CLAIMS FOR BENEFITS

21.01 Consideration of Initial Claim.

(a) Filing Initial Claim. The Claims Administrator shall process benefit claims pursuant to the procedures set forth below. Initial claims shall be filed within eighteen months from the date a charge is incurred. The Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator may decide benefit claims requiring a determination of whether an individual meets the requirements for eligibility under the terms of the Plan, which determination may result in a denial, reduction, or termination of, or failure to provide payment for, a benefit. Solely with respect to claims involving a determination of an individual's eligibility under the Plan, the term "Claims Administrator" as used in this Article shall refer also to the Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator.

(b) Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to permit a determination whether, or to what extent, benefits are covered or payable under the Plan. If the claimant does not provide sufficient information for the Claims Administrator to make such determination, then within 24 hours after the Claims Administrator's receipt of the claim, the claimant shall be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Claims Administrator shall notify the claimant of its decision regarding the claim within 48 hours of the earlier of (i) the Claims Administrator's receipt of the specified information, or (ii) the end of the period afforded the claimant to provide the specified additional information.

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 the ability of the patient to regain maximum function, or in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the

initial 15-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within five days after receipt of the claim he or she shall be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Pre-Service Claim" is any claim where the Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide notice of an adverse benefit determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Plan if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, the claimant shall receive notice of the specific information necessary to complete the claim. Once the claimant is notified he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Post-Service Claim" is any claim that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

(e) Concurrent Care Claims. In the case of an ongoing course of treatment, the claimant shall receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Claims Administrator shall notify the claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. If the request to extend any ongoing course of treatment is not an Urgent Care Claim, the Claims Administrator will treat the claim as either a Pre-Service Claim or a Post-Service Claim (as applicable) and will consider the claim according to the timeframes applicable to Pre-Service Claims or Post-Service Claims, whichever applies. The Claims Administrator shall be solely responsible for handling all Concurrent Care Claims.

A "Concurrent Care Claim" is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding a request by a claimant to extend a course of treatment beyond what has been approved.

21.02 If the Claims Administrator Makes an Adverse Benefit Determination Regarding the Initial Claim. If the Claims Administrator makes an adverse benefit determination, it shall provide notice of the adverse benefit determination that (1) includes 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; (2)

explains the specific reason for the adverse benefit determination; (3) refers to the specific Plan provisions on which the adverse benefit determination is based; (4) describes any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (5) describes the Plan's review procedures (as set forth below) 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 the claimant's right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and (6) to the extent required by applicable regulations, discloses the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman who may assist the claimant. An "adverse benefit determination" means (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in 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" means 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 claimant's failure to pay on a timely basis premiums or contributions towards the cost of coverage.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Claims Administrator denies a claimant's Urgent Care Claim in whole or in part, the Claims Administrator shall provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Claims Administrator shall provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

21.03 Mandatory First-Level Internal Appeal to the Claims Administrator.

(a) General. If the Claims Administrator makes an adverse benefit determination, a claimant or his or her duly authorized representative may request a review of such adverse benefit determination by the Claims Administrator by sending a written request for review to the Claims Administrator within 180 days of receipt of the Claims Administrator's notice of adverse benefit determination.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied or the coverage should not have been rescinded. The claimant's request shall include any adverse benefit determination letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

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

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 consultant 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 the claimant upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Expedited Review for Urgent Care Claims. In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, the claimant or the claimant's authorized representative must contact the Claims Administrator and provide at least the following information: (1) the claimant's name; (2) the date(s) of the medical service; (3) the specific medical condition or symptom; (4) the provider's name; (5) the service or supply for which approval of benefits was sought; and (6) any reasons why the appeal should be processed on a more expedited basis. The Claims Administrator shall notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review.

21.04 If the Claims Administrator Makes an Adverse Benefit Determination on a Mandatory First-Level Internal Appeal. If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal, it shall provide notice, in a manner calculated to be understood by the claimant of the adverse benefit determination (such determination a "final adverse benefit determination"), which notice shall (1) to the extent required by applicable regulations, 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; (2) explain the specific reason for the adverse benefit determination; (3) refer to the specific Plan provisions on which the adverse benefit determination is based; (4) state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (5) describe any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; (6) describe available internal appeals and external review processes, including information regarding how to initiate an appeal; (7) indicate that a claimant has a right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and (8) 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 the claimant.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

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

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

21.05 Voluntary Second-Level Internal Appeal to the Claims Administrator of Pre- and Post-Service Claim Denials.

(a) General. If the Claims Administrator makes an adverse benefit determination with respect to a Pre-Service Claim or a Post-Service Claim on a mandatory first-level internal appeal, a claimant or his or her duly authorized representative may request a review of such adverse benefit determination by the Claims Administrator by sending a written request for a voluntary second-level internal appeal to the Claims Administrator within 60 days of receipt of the Claims Administrator's notice of denial of the mandatory first-level internal appeal. A claimant is not required to request a voluntary second-level internal appeal before submitting a request for an independent external review. However,

if a claimant requests a voluntary second-level internal appeal, the claimant must obtain a determination on such appeal before requesting an independent external review.

The Plan waives any right to assert that a claimant failed to exhaust administrative remedies because the claimant 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 a claimant with information relating to the voluntary second-level internal appeal to enable the clamant to make an informed judgment about whether to request such an appeal. A claimant's decision whether or not to request a voluntary second-level internal appeal will have no effect on such claimant's right to any other benefits under the Plan.

Requests for review should be sent to the Claims Administrator at the address furnished by the Plan Administrator from time to time.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

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

If the denial 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 consultant 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 the claimant upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(c) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable

period of time, but not later than 60 days after receipt of the claimant's request for review.

21.06 If the Claims Administrator Makes an Adverse Benefit Determination on a Voluntary Second-Level Internal Appeal. If the Claims Administrator makes an adverse benefit determination on a voluntary second-level internal appeal, it shall provide notice, in a manner calculated to be understood by the claimant of the adverse benefit determination, which notice shall (1) to the extent required by applicable regulations, 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; (2) explain the specific reason for the adverse benefit determination; (3) refer to the specific Plan provisions on which the adverse benefit determination is based; (4) state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (5) describe any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; (6) describe available internal appeals and external review processes, including information regarding how to initiate an appeal; (7) indicate that a claimant has a right to bring a civil action under section 502(a) of ERISA following a final adverse benefit determination; and (8) 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 the claimant.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

21.07 Full and Fair Review. In connection with a claim or internal appeal, the Claims Administrator will provide a claimant, 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 a 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 addition, before a claimant receives a final internal adverse benefit determination on review based upon a new or additional rationale, the Claims Administrator will provide to the claimant, 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.

21.08 Voluntary External Review by Independent Review Organization.

(a) General. If the Claims Administrator makes an adverse benefit determination or final adverse benefit determination, a claimant may be entitled to obtain an independent external review pursuant to federal law. 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 a claimant fails to meet the requirements for eligibility under the terms of the Plan. A claimant does not need to pursue an external review in order to complete or exhaust the appeal procedure described above. A claimant's decision to seek an independent external review will not affect the claimant's rights to any other benefits under the Plan. There is no charge to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

(b) Standard External Review. This subsection (b) sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described in subsection (c) below).

(1) If the Claims Administrator makes an adverse benefit determination or a final adverse benefit determination, a claimant or his or her duly authorized representative may file a request for an external review under federal law within four months of the date the claimant received notice of an adverse benefit determination or final internal adverse benefit determination. A claimant's request must be in writing, unless the Claims Administrator determines that it is not reasonable to require a written statement. A claimant does not have to resubmit information that was submitted for the initial claim or internal appeal.

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

(A) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(B) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan and does involve medical judgment or a rescission of coverage;

(C) The claimant has exhausted the Plan's internal appeal process, unless the claimant is not required to exhaust such process under applicable federal regulations;

(D) The claimant has provided all the information and forms required to process an external review.

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

(4) The assigned IRO is required to notify the claimant in writing of the eligibility of the request and of the acceptance of the request for external review. Within ten business days following the date of the claimant's receipt of such notice, the claimant 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.

(5) 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 the claimant and the Plan within one business day after making any such decision.

(6) Upon receipt of any information submitted by the claimant, 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 the claimant and to the assigned IRO. The assigned IRO is required to terminate the external review upon receipt of any such notice from the Plan.

(7) 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 will 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:

(A) The claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents

(D) The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan;

(E) 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;

(F) 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;

(G) 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.

(8) 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 the claimant and to the Plan. The assigned IRO's decision notice on external review will contain:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim;

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) 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;

(E) 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 the claimant;

(F) A statement that judicial review may be available to the claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

(c) Expedited External Review. This subsection (c) sets forth procedures for expedited external review.

(1) If the Claims Administrator makes an adverse benefit determination or final adverse benefit determination, and the claim is an urgent care claim or a concurrent care claim, the claimant 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.

(2) The claimant or his or her 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 the claimant by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited external review, the

claimant or his or her authorized representative must contact the Claims Administrator and provide at least the following information:

(A) The claimant's name;

(B) The date(s) of the medical service;

(C) The specific medical condition or symptom;

(D) The provider's name

(E) The service or supply for which approval of benefits was sought; and

(F) Any reasons why the appeal should be processed on a more expedited basis.

(3) Upon receipt of a 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 the claimant in writing of the results of such review.

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

(5) 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 a claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(6) The IRO is required to notify the claimant of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives a 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 the claimant and to the Plan.

21.09 Limitations Upon Civil Actions. No civil action regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals described in this Article XXI (but not including any voluntary appeal provided for in Section 21.05) has been exhausted. In addition, in no event may any civil action regarding a claim for benefits or a rescission of coverage be commenced later than three years after the date such claim was incurred or the date of the rescission of coverage, as the case may be. A claim for benefits is incurred when the services giving rise to the claim were rendered.

21.10 Construction of Article. This Article shall be construed in a manner consistent with Department of Labor Regulations governing claims procedures applicable to group health plans.

ARTICLE XXII
TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE

22.01 Cessation of Participation. Except as otherwise provided in this Article:

(a) An Employee shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date that the Plan is amended to terminate coverage with respect to an Employee;

(3) The date of death of the Employee;

(4) The last day of the month in which an Employee is no longer eligible for coverage under Article III, including without limitation as a result of the Employee's employer no longer being a Related Employer;

(5) The last day of the month in which an Employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided in the NiSource Military Leave of Absence Policy;

(6) The last day of the last month for which any required Covered Person Contribution was made, in the case of cessation of required Covered Person contributions;

(7) The last day of the month in which a leave of absence begins, except to the extent continuation coverage is required under Section 22.02 (relating to coverage required by the FMLA); or

(8) The last day of the month in which an Employee terminates employment, unless the Employee elects coverage as a Retiree prior to his or her retirement.

If, after the Employee ceases to be actively employed due to his or her purported disability or other approved leave status, an Employer under its personnel policies continues to treat an individual as an Employee generally eligible for health and welfare benefits offered by the Employer, then the Employee will continue to be treated as an Employee eligible to participate in the Plan, subject to the terms and conditions of the Plan. Provided, however, that such participation shall cease upon the earliest of any event set forth in (1) through (6) and (8) above.

(b) A Retiree shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date the Retiree attains age 65;

(3) The date of the death of the Retiree;

(4) The last day of the month in which a Retiree is no longer eligible for coverage under Article III, including without limitation as a result of the Retiree's former

employer no longer being a Related Employer, unless the Plan Administrator determines, in its discretion, that such event shall not cause a loss of coverage;

(5) The Separation Date, with respect to any Retiree who retired from employment with a Columbia Divested Company;

(6) The last day of the last month for which any required Covered Person Contribution was made, in the case of cessation of required Covered Person Contributions; or

(7) The date Retiree coverage ceases pursuant to any Plan amendment.

(c) A Dependent of an Employee or Retiree shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The last day of the month in which the Employee's or Retiree's coverage ends, except that

(A) if coverage ended due to the death of the Employee or Retiree before January 1, 2004, and if COBRA continuation coverage was elected by or on behalf of such Dependent who was a Qualified Beneficiary and such coverage was not terminated for any reason prior to the maximum continuation coverage period specified in Section 22.05 being exhausted, then coverage under the Plan may be continued for such Dependent in accordance with a written plan or procedure, if any, applicable to such Employee or Retiree that was adopted by the Company and in effect as of December 31, 2003, as such plan or procedure was thereafter, or may hereafter, be modified by the Company; provided, however, that such coverage shall cease as of the Separation Date if the Employee's or Retiree's last employment was with a Columbia Divested Company or a CPG Related Employer. If such Dependent's COBRA continuation coverage terminated for any reason before the maximum COBRA continuation coverage period was exhausted, or if any coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason (including without limitation the voluntary relinquishment of such coverage), no further coverage is available under the Plan;

(B) if coverage ends due to the death of the Employee (other than a Bay State Gas Company Represented Employee or a NIPSCO Represented Employee who is a Temporary ManPower Pool, Temporary Work Force or Part-Time Employee) on or after January 1, 2004, and if COBRA Continuation Coverage or COBRA-like continuation coverage is elected by or on behalf of such Dependent who is a Qualified Beneficiary and such coverage is not terminated prior to the maximum continuation coverage period specified in Section 22.05 being exhausted, then coverage under the Plan may be continued for such Dependent until the earliest of (i) the date of the death of the Employee's Spouse or Same-Sex Domestic Partner; (ii) the last day of the month in which the Employee's Spouse or Same-Sex Domestic Partner remarries or enters

into a domestic partnership or civil union with another person; (iii) the last day of the last month for which any required Covered Person Contributions for such coverage are made, in the case of cessation of required Covered Person Contributions; (iv) with respect to a Dependent Child, the last day of the month in which such Dependent would no longer be considered a Dependent under the Plan, had the Employee survived; (v) with respect to any Dependent of an Employee, the date such Dependent attains age 65; (vi) the Separation Date, in the case of an Employee whose last employment was with a Columbia Divested Company or CPG Related Employer; and (vii) the date the Employer of such Employee ceases to be a Related Employer, unless the Plan Administrator determines, in its discretion, that such event shall not cause a loss of coverage. If such Dependent's COBRA Continuation Coverage or COBRA-like continuation coverage terminates for any reason before the maximum COBRA continuation coverage period has been exhausted, or if any coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason (including without limitation the voluntary relinquishment of such coverage), no further coverage is available under the Plan;

(C) if coverage ends due to the death of a Bay State Gas Company Represented Employee, a NIPSCO Represented Part-Time Employee (excluding any Employee who is a Temporary ManPower Pool or Temporary Work Force Employee), or a Retiree within thirty days preceding, or at any time on or after, May 1, 2010, and if COBRA Continuation Coverage or COBRA-like continuation coverage is elected by or on behalf of such Dependent who is a Qualified Beneficiary and such coverage is not terminated prior to the maximum continuation coverage period specified in Section 22.05 being exhausted, then coverage under the Plan may be continued for such Dependent until the earliest of (i) the date of the death of the Employee's or Retiree's Spouse or Same-Sex Domestic Partner; (ii) the last day of the month in which the Employee's or Retiree's Spouse or Same-Sex Domestic Partner remarries or enters into a domestic partnership or civil union with another person; (iii) the last day of the last month for which any required Covered Person Contributions for such coverage are made, in the case of cessation of required Covered Person Contributions; (iv) with respect to a Dependent Child, the last day of the month in which such Dependent would no longer be considered a Dependent under the Plan, had the Employee or Retiree survived; (v) with respect to any Dependent of an Employee or Retiree, the date such Dependent attains age 65; (vi) the Separation Date, in the case of an Employee whose last employment was with a Columbia Divested Company or CPG Related Employer; and (vii) the date the Employer of such Employee or Retiree ceases to be a Related Employer, unless the Plan Administrator determines, in its discretion, that such event shall not cause a loss of coverage. If such Dependent's COBRA Continuation Coverage or COBRA-like continuation coverage terminates for any reason before the maximum COBRA continuation coverage period has been exhausted, or if any coverage provided beyond the maximum COBRA continuation coverage period is terminated for any reason (including without limitation the

voluntary relinquishment of such coverage), no further coverage is available under the Plan;

(D) if a Retiree's coverage under this Plan ends because such Retiree attains age 65, and if such Retiree timely and properly enrolls in the Post-65 Retiree Medical Plan, the Dependent's coverage under this Plan may continue, subject to the other terms and conditions of this Plan, if the Dependent is otherwise eligible for coverage hereunder; and

(E) if coverage ends due to the death of any other Employee or Retiree, coverage for his or her Dependents will end on the date of the Employee's or Retiree's death;

(3) The last day of the last month for which any required Covered Person Contributions for Dependent coverage were made, in the case of cessation of required Covered Person Contributions; or

(4) The last day of the month in which a Dependent no longer qualifies as a Dependent.

22.02 Leave of Absence Under the FMLA. Eligibility for Plan coverage shall continue for an Employee who is granted a leave of absence under the FMLA at the same level of contribution and under the same conditions as if the Employee had continued in employment. However, to the extent permitted by the FMLA, the Company may recover from the Employee its cost of coverage and benefits provided hereunder if the Employee fails to return from leave for reasons other than the continuation or onset of a serious health condition (as defined in the FMLA), or other circumstances beyond the control of the Employee. The Company may require that a claim that an Employee is unable to return to work because of the continuation, recurrence, or onset of a serious health condition be supported by certification of a health care provider.

22.03 Military Leave Policy. Coverage for a Covered Person shall continue to the extent provided under the NiSource Military Leave of Absence Policy and as required by applicable state or federal law.

22.04 Severance. Eligibility for Plan coverage shall continue for an Employee to the extent provided under any severance arrangement between such Employee and the Company. The level of contribution and the conditions of such continuation coverage shall be determined by the terms of the applicable severance agreement. The Plan's COBRA continuation of coverage provisions will be available to the extent required by law. Unless a severance arrangement expressly provides to the contrary, continuation coverage pursuant to this Section shall be deemed to be "subsidized COBRA Continuation Coverage" and shall count towards the maximum COBRA Continuation Coverage period.

22.05 COBRA. The Plan offers continuation of coverage to the extent required by COBRA.

(a) Continuation of Coverage. If Plan coverage ends because of a Qualifying Event, a Qualified Beneficiary may elect to continue the Coverage Option in force immediately prior to the Qualifying Event, subject to the provisions below.

(b) Election Period. A Qualified Beneficiary may elect COBRA Continuation Coverage only during the election period. The election period begins on the date of the Qualifying Event and ends on the later of (1) 60 days after the date coverage would have stopped due

to the Qualifying Event; or (2) 60 days after the date the Qualified Beneficiary is sent notice of the right to continue coverage under COBRA.

A Covered Employee or Spouse's election of COBRA Continuation Coverage shall be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

If COBRA Continuation Coverage is elected within the election period, coverage shall be reinstated retroactively to the date of the Qualifying Event. If a Qualified Beneficiary waives COBRA Continuation Coverage during the election period, the Qualified Beneficiary may revoke that waiver at any time before the end of the election period and elect COBRA Continuation Coverage retroactive to the date of the Qualifying Event.

(c) Coverage Period. COBRA Continuation Coverage shall begin as of the date of the Qualifying Event and shall continue until the earliest of the following dates:

(1) The date the Qualified Beneficiary first becomes entitled to benefits under Medicare.

(2) 18 months from the date of a Qualifying Event set forth in subsection 2.83(a) or (b).

(3) If a Qualifying Event set forth in subsection 2.84(a) or (b) occurs less than 18 months after the date a Covered Employee becomes entitled to Medicare benefits, the period of coverage for each Qualified Beneficiary other than the Covered Employee shall not terminate before the close of the 36-month period beginning on the date the Covered Employee becomes entitled to Medicare.

(4) If any Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time before the 61st day of COBRA Continuation Coverage resulting from a Qualifying Event set forth in subsection 2.84(a) or (b), any Qualified Beneficiary may elect an additional 11 months of COBRA Continuation Coverage if:

(A) The disabled Qualified Beneficiary provides the Plan Administrator with the Social Security Administration's determination of disability (i) within 60 days of the later of date the determination is issued and the date the Qualified Beneficiary loses coverage under the Plan as a result of the Qualifying Event, and (ii) within the initial 18 month COBRA Continuation period; and

(B) The Qualified Beneficiary agrees to pay the increased Covered Person Contribution necessary to continue the coverage for the additional 11 months.

COBRA Continuation Coverage shall automatically end before the additional 11-month period ends on the first day of the month coincident with or next following 30 days from the date that the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

(5) 36 months from the date coverage would have ended due to a Qualifying Event other than that set forth in subsection 2.84(a) or (b).

(6) The date on which the Company ceases to provide any Group Health Plan to any Employee.

(7) If the Qualified Beneficiary fails to make a required Covered Person Contribution, the end of the period for which the last Contribution was made.

(8) The date the 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, and such pre-existing condition limitation is permissible pursuant to HIPAA.

(9) In the case of a Qualifying Event described in subsection 2.84(g), the date of death of the Retiree or, for a Qualified Beneficiary (described in subsection 2.83(c)) who is the surviving Spouse or Dependent Child of the Retiree, the earlier of the date of such Qualified Beneficiary's death or 36 months after the date of the death of the Retiree.

(10) The Separation Date, in the case of a person (A) who (i) is a former employee of the Company or of a Related Employer, of a CPG Related Employer, or of a Columbia Divested Company, and whose last employment with any of such parties prior to termination of employment was with a CPG Related Employer or a Columbia Divested Company (a "CPG Participant"), or (ii) is or was a dependent of a CPG Participant or of an employee of CPG or of a CPG Related Employer; and (B) whose coverage under the Plan ended prior to the Separation Date because of a Qualifying Event.

(d) Multiple Qualifying Events. If after the first Qualifying Event another Qualifying Event occurs, coverage may be continued for an additional period, up to 36 months from the first Qualifying Event.

(e) Notification Requirements. A Qualified Beneficiary shall notify the Plan Administrator within 60 days of the Qualifying Events set forth in subsection 2.84(e) or (f) or of a second Qualifying Event described in subsection 22.05(d). If such notice is not given, the Qualified Beneficiary shall not be eligible for COBRA Continuation Coverage.

(f) Required Contributions. Except as provided in subsection 22.05(g), the Company will not make any contribution toward the cost of COBRA Continuation Coverage. A Qualified Beneficiary electing COBRA Continuation Coverage shall be responsible for a Covered Person Contribution in the amount of 102% of what is calculated to be the total cost of the Coverage Option being continued, or in the case of an individual who is entitled to extended COBRA Continuation Coverage beyond 18 months pursuant to subsection 22.05(c)(4), 150% of what is calculated to be the average cost of the Coverage Option being continued. Premiums for the period of COBRA Continuation Coverage prior to the date of the election will be due 45 days after the COBRA Continuation Coverage is elected. Thereafter, monthly premiums shall be due the first day of the calendar month. There shall be a grace period of 30 days for the payment of regularly scheduled monthly premiums.

(g) Subsidized COBRA. The Company may subsidize all or a portion of the cost of COBRA Continuation Coverage. If the Company so elects, the period of such subsidized coverage shall count towards the COBRA Continuation Coverage period required under this Section.

(h) COBRA-Like Continuation Coverage for Same-Sex Domestic Partners. The Plan will make COBRA-like continuation coverage available to a Same-Sex Domestic Partner who is a Covered Person (and to a Same-Sex Domestic Partner's Child who is a Covered Person) under circumstances, and subject to the same, terms, conditions and limitations, that would entitle the lawful Spouse or Child of a Covered Participant to elect COBRA continuation coverage. A Same-Sex Domestic Partner and a Child of a Same-Sex Domestic Partner shall have the same notice and other obligations with respect to such continuation coverage as a lawful Spouse or Child of a Covered Participant has with respect to COBRA continuation coverage. For purposes of this COBRA-like continuation coverage, a termination of a same-sex domestic partner relationship will be treated as a divorce.

ARTICLE XXIII
PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION

23.01 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 Plan must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

23.02 Permitted Uses and Disclosure. The Plan may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plan 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 Plan or the Privacy Standards.

23.03 Disclosures to Company. The Plan 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 Plan 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.

The Company, in its capacity as sponsor of the Plan, agrees to:

(a) not use or further disclose Protected Health Information received from the Plan other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

(c) not use or disclose Protected Health Information received from the Plan for employment-related actions and decisions;

(d) not use or disclose Protected Health Information received from the Plan in connection with any other benefit or employee benefit plan of the Company (except to the extent that such other benefit, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan is a part);

(e) report to the Privacy Official, acting on behalf of the Plan, any use or disclosure of Protected Health Information received from the Plan that is inconsistent with the uses or disclosures authorized by this Section and of which the Company becomes aware;

(f) make available Protected Health Information in accordance with 45 C.F.R. § 164.524 (pertaining to an individual's access to his or her own Protected Health Information) and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(g) make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(i) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("HHS") or to any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with 45 C.F.R. Subchapter C, Subpart E; and

(j) if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The foregoing restrictions do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the Company or any other Employer, acting in their respective capacities as an employer.

23.04 Adequate Separation. There shall be adequate separation between the Plan and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the following employees, classes of employees or other persons under the control of the Company or its affiliates may have access to Protected Health Information created under the Plan:

Privacy Official
Security Official
Members of the Benefits Department
HRIS-Benefits Analyst
Members of the Legal Department
Members of the Internal Audit Department
Members of the Committee
Any other employee of the Company or its affiliates who performs plan administration functions for the Plan and who is designated in writing by the Privacy Official or a member of the Committee as being entitled to access to Protected Health Information.

Access to and use by such individuals shall be restricted to the plan administration functions that the Company and its affiliates perform for the Plan. The Plan or the Company (or an affiliate) has 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 Plan. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plan governing their obligations under the Privacy Standards.

23.05 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 Plan. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

23.06 Special Amendatory Authority. The Privacy Official appointed by the Plan Administrator pursuant to the Privacy Standards shall be authorized to make and execute any amendment to this Article that such Privacy Official deems necessary or appropriate.

ARTICLE XXIV
PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

24.01 General. The Department of Health and Human Services has issued Regulations, effective April 20, 2005, that govern the manner in which a group health plan, such as the Plan, must handle Electronic Protected Health Information. "Electronic Protected Health Information" refers to Protected Health Information that is (i) maintained in Electronic Media (as defined in 45 C.F.R. Section 160.103), or (ii) transmitted by Electronic Media.

24.02 Duty of the Plan Sponsor. The Company shall reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted to or by the Company on behalf of the Plan. To this end, the Company shall: (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Company creates, receives, maintains or transmits on behalf of the Plan; (ii) ensure that the adequate separation required by Section 23.04 above is supported by reasonable and appropriate security measures; (iii) ensure that any agent, including a subcontractor, to whom or which the Company provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and (iv) report to the Plan any security incident involving Electronic Protected Health Information of which the Company becomes aware.

ARTICLE XXV
MISCELLANEOUS PROVISIONS

25.01 Assignment of Benefits. Except as required by applicable law, no right or interest of any Covered Person, and no benefit payable at any time, under the 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 the Plan be liable for, or subject to, any obligation or liability of any Covered Person. Without limiting the generality of the foregoing, except as required by applicable law, no

Covered Person may 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 the 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 the Plan, and any such attempted assignment or transfer is void.

Nothing contained herein, nor any course of dealing, act or omission on the part of the Plan, the Plan Administrator or any Claims Administrator or other party, shall be construed to make the Plan liable to any third party to whom a Covered Person may be liable for medical care, treatment, services or supplies. Although the Plan may, at the direction of a Covered Person or otherwise, make payments directly to persons or institutions providing Covered Services under the Plan, no such direction or payment shall be deemed to constitute an assignment, or an acknowledgment or acceptance of any purported assignment, of any benefits or other rights or interests under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by the Plan shall constitute a complete discharge of the obligation of the Plan to such Covered Person. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to a Covered Person be deemed a participant or beneficiary under the Plan.

If any Covered Person entitled to a benefit under the Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part, or if by reason of his or her bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then upon becoming aware of any 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 his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her Dependents, in a manner the Plan Administrator may deem proper.

25.02 Information To Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

25.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

25.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Covered Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

25.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like

character and with like aims; and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

25.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

25.07 Misrepresentation. Any material misrepresentation on the part of any Covered Person in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void. Without limiting the generality of the foregoing, a Covered Participant's enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under the Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including termination of employment.

25.08 Inadvertent Error. Inadvertent error by the Plan Administrator in the keeping of records or the transmission of any Enrollment Form shall not deprive any Covered Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

25.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the rights of the Company or of any Employer to discipline or terminate an Employee.

25.10 No Liability for Acts of Any Provider. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan for the acts of any Hospital in which he or she receives care, or for the acts of any Physician from whom he or she receives service under this Plan.

25.11 Covered Person's Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect; (2) the Covered Person does not respond to the notice sent to the current address; (3) there are conflicting claims to such payment; or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest. Each Covered Participant shall also notify the Plan in writing when any person is no longer eligible for coverage as his or her Dependent hereunder.

25.12 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to offset the overpaid amount against future benefits that are payable or to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization. Without limiting the generality of the foregoing, the Plan shall have the right to recover any amounts it pays in respect of a person who is not an eligible Participant or Dependent.

25.13 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 25.13 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

25.14 Severability. In the event any portion of this Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Plan, and the balance of the Plan shall remain in full force and effect.

25.15 Participant Litigation. In any action or proceeding involving the Plan, Covered Persons or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

25.16 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

25.17 Notice. Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Claims Administrator, when addressed to it at its home office; or if given to a Covered Participant, when addressed to the Covered Participant at his or her address as it appears on the records of the Claims Administrator.

25.18 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees and Retirees to become Covered Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required

contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XXVI
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

26.01 Plan Self-Insured. The Plan is a self-insured plan. All contributions made to the Plan are used to pay claims and related expenses thereunder.

26.02 Participants' and Dependents' Rights Unsecured. The right of a Covered Person or any other person to receive a distribution hereunder, shall be an unsecured claim against the general assets of the Company and no Covered Person or any other person shall have any rights in any amount allocated for his or her benefit under the terms of the Plan, or any other specific assets of the Company. All amounts allocated pursuant to the terms of the Plan shall constitute general assets of the Company and may be disposed of by the Committee at such time and for such purpose as it may deem appropriate. Benefits payable pursuant to the terms of the Plan shall be paid solely as required out of the general assets of the Company or from any other funding vehicle as may be established by the Company.

26.03 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Unless expressly provided, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration. To the extent that any applicable collective bargaining agreement imposes a more restrictive requirement regarding Plan eligibility or benefits than is set forth herein, such requirement, as applied solely to those Represented Employees or Retirees subject to the collective bargaining agreement, is incorporated herein by this reference. Notwithstanding anything contained herein to the contrary, any change or amendment (other than a Plan administration change, the addition or deletion of network providers, drug formulary changes or similar changes) affecting coverage for any NIPSCO Represented Employee, Retiree or Dependent shall only be made effective as of January 1 of any year, and notification of such change or amendment shall be made to affected NIPSCO Represented Employees or Retirees during the Annual Enrollment Period.

26.04 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

26.05 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Remainder of page intentionally left blank]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 6th day of December, 2017, to be effective as of January 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

SCHEDULE 1
PRE-65 RETIREE BENEFIT PROGRAM MATRIX

Summary of Plan Provisions

Summary of Pre-65 Medical Plan Provisions

This section highlights the key pre-65 medical plan provisions reflected in the December 31, 2015 measurement.

Eligibility for Participation	Immediate. Groups excluded from coverage are noted in table below.
Eligibility for Benefits	Age 55 and 10 years of service.
Continuation to Spouses of Deceased Retirees	Coverage continues until death of spouse or until spouse remarries.
Available Coverage[1]	NIPSCO Union PPO Nonunion PPO PPO HD PPO 1 HD PPO 2 Various HMOs by location
Medical Plan Options	See table below.
Cost Sharing	See table below.

[1] For detail on specific plan benefit provisions, see applicable NiSource plan documents.

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
101	All Nonunion Exempt FT retired on or after 02/01/2004 and before 02/01/2006 and Non-Exempt FT retired on or after 02/01/2004 and hired before 01/01/2013	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
101A	Bay State Nonunion FT retired on or before 01/01/2002	Nonunion PPO HD PPO 1 HD PPO 2 Tufts HMO Anthem NH-ME HMO	80% of "You Only" premium and 50% of premium for all other tiers until age 60, then 100% of premium (all active/pre65 blended)
101B	Bay State Nonunion FT retired after 01/01/2002 and age 45 or older as of 01/01/1992 and hired before 09/01/1990 and elected retiree medical coverage and waived special saving plans match	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
101C	Bay State Nonunion FT retired between 01/01/2002 and 02/01/2004	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	85% of premium (active/pre-65 for HMOs), not to exceed 103% of prior year's subsidy
101D	CEG Nonunion FT retired before 01/01/1993	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
101E	CEG Nonunion FT retired after 01/01/1993 and before 02/01/2004 and hired before 01/01/1993	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
101F	CEG Nonunion FT retired after 01/01/1993 and before 02/01/2004 and hired after 01/01/1993	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	50% of active/pre-65 premium

GAS-RR-024
Attachment B
Page 101 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
101G	Columbia Nonunion FT—2002 ERW/VSP Age 50–52 (Salary continuation)	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
101H	Columbia Nonunion FT—2002 ERW/VSP Group Age 53–55, retired on or after 02/01/2004	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
101I	Kokomo Nonunion FT retired before 01/01/2002	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
101J	Kokomo Nonunion FT retired between 01/01/2002 and 02/01/2004	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	85% of premium (active/pre-65 for HMOs), not to exceed 103% of prior year's subsidy
101K	NiSource Nonunion FT retired on or before 02/01/1997	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	85% of premium (active/pre-65 for HMOs)
101L	NiSource Nonunion FT retired after 02/01/1997 and before 02/01/2004	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	85% of premium (active/pre-65 for HMOs), not to exceed 103% of prior year's subsidy
101M	NIFL FT retired before 01/01/2002	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Retiree pays same contribution as nonexempt nonunion actives
101N	NIFL FT retired after 01/01/2002 and prior to 02/01/2004; retirement eligible as of 12/31/2001	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Retiree pays same contribution as nonexempt nonunion actives

GAS-RR-024
Attachment B
Page 102 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
101O	NIFL FT retired after 01/01/2002 and retired prior to 02/01/2004 and not retirement eligible as of 01/01/2002	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	85% of premium (active/pre-65 for HMOs), not to exceed 103% of prior year's subsidy
102	All Nonunion Exempt PT retired on or after 02/01/2004 and before 02/01/2006 and Non-Exempt PT retired on or after 02/01/2004 and hired before 01/01/2013	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
102D	Columbia Nonunion PT—2002 ERW/VSP Age 50–52	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
104	All Nonunion Exempt FT retired on or after 02/01/2006 and hired before 01/01/2010	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
105	All Nonunion Exempt PT retired on or after 02/01/2006 and hired before 01/01/2010	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
132	Special 4th Quarter FT VSP retired before 02/01/2004	Nonunion PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
221	NIPSCO Union FT retired prior to 01/01/2005	NIPSCO Union PPO HD PPO 1 HD PPO 2	85% of active/pre-65 premium
221Y05	NIPSCO Union FT hired before 06/01/2004 and retired on or after 01/01/2005 and before 01/01/2015	NIPSCO Union PPO HD PPO 1 HD PPO 2	77% of active/pre-65 premium

GAS-RR-024
Attachment B
Page 103 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
221Y14	NIPSCO Union FT retired before 01/01/2015, and hired on or after 06/01/2004 and before 06/01/2009	NIPSCO Union PPO HD PPO 1 HD PPO 2	70% of active/pre-65 premium
221Y15	NIPSCO Union FT hired before 06/01/2004 and retiring on or after 01/01/2015	NIPSCO Union PPO HD PPO 1 HD PPO 2	Retirements before 01/02/2017 get choice between: (a) Defined Dollar $180 x service retiree[1] $125 x service spouse[2] (b) 77% of active/pre-65 premium Retirements on or after 01/02/2017 get Defined Dollar as described above.
225Y15	NIPSCO Union FT retiring on or after 01/01/2015, and hired on or after 06/01/2004 and before 06/01/2009	NIPSCO Union PPO HD PPO 1 HD PPO 2	Retirements before 01/02/2017 get choice between: (a) Defined Dollar $180 x service retiree[1] $125 x service spouse[2] (b) 70% of active/pre-65 premium Retirements on or after 01/02/2017 get Defined Dollar as described above.
226	NIPSCO Union FT hired on or after 06/01/2009 and retiring on or after 6/1/2019	NIPSCO Union PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree[1] $125 x service spouse[2]
321	NIFL Union FT retired on or after 01/01/2006 but before 01/01/2012	PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree $125 x service spouse

[1] Defined Dollar increases to $190 x service effective 01/01/2017 and to $225 x service effective 01/01/2019. Retiree who timely elects Defined Dollar and is otherwise eligible to contribute to an HSA is entitled to a one-time HSA contribution of $1,500 for retirements in 2015-2018 and $1,200 for retirements in 2019. The HSA employer contribution is subject to IRS limits on maximum annual contributions.

[2] Defined Dollar increases to $135 x service effective 01/01/2017 and to $170 x service effective 01/01/2019.

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
321Y12	NIFL Union FT retired on or after 01/01/2012 but before 01/01/2015 and hired before 01/01/2012	NIPSCO Union PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree[1] $125 x service spouse[2]
321Y15	NIFL Union FT retired on or after 01/01/2015 and hired before 01/01/2012	NIPSCO Union PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree[3] $125 x service spouse[2]
621	CEG Union FT retired after 01/01/2004 and hired before 01/01/2013	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
621A	CEG Union FT retired before 01/01/1993	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
621B	CEG Union FT retired after 01/01/1993 and before 02/01/2004 and hired before 01/01/1993	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
621C	CEG Union FT retired after 01/01/1993 and before 02/01/2004 and hired after 01/01/1993	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	50% of active/pre-65 premium
621D	CEG Union FT—2002 ERW/VSP Group Age 50–52 (Salary Continuation)	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse

[1] Defined Dollar increases to $190 x service effective 01/01/2017 and to $225 x service effective 01/01/2019.
[2] Defined Dollar increases to $135 x service effective 01/01/2017 and to $170 x service effective 01/01/2019.
[3] Defined Dollar increases to $190 x service effective 01/01/2017 and to $225 x service effective 01/01/2019. Retiree who timely elects Defined Dollar and is otherwise eligible to contribute to an HSA is entitled to a one-time HSA contribution of $1,500 for retirements in 2015-2018 and $1,200 for retirements in 2019. The HSA employer contribution is subject to IRS limits on maximum annual contributions.

GAS-RR-024
Attachment B
Page 105 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
621E	CEG Union FT—2002 ERW/VSP Group Age 53–55, retired on or after 02/01/2004	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	100% of premium
622	CEG Union PT retired after 02/01/2004 and hired before 01/01/2013	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	Defined Dollar $180 x service retiree $125 x service spouse
622C	CEG Union PT retired after 01/01/1993 and before 02/01/2004 and hired after 01/01/2003	PPO HD PPO 1 HD PPO 2 HMOs for Service Area	50% of active/pre-65 premium
721Y05	Kokomo Union FT Outside (majority) retired after 01/01/2005 but before 01/01/2012	NIPSCO Union PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree $125 x service spouse
721Y12	Kokomo Union FT retired on or after 01/01/2012 but before 01/01/2015 and hired before 01/01/2012	NIPSCO Union PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree[1] $125 x service spouse[2]
721Y15	Kokomo Union FT retired on or after 01/01/2015 and hired before 01/01/2012	NIPSCO Union PPO HD PPO 1 HD PPO 2	Defined Dollar $180 x service retiree[3] $125 x service spouse[2]
821	Bay State Union Brockton Physical FT hired before 01/01/2013 and does not meet requirements of 821A	PPO HD PPO 1 HD PPO 2 Tufts HMO	Defined Dollar $180 x service retiree $125 x service spouse

[1] Defined Dollar increases to $190 x service effective 01/01/2017 and to $225 x service effective 01/01/2019.
[2] Defined Dollar increases to $135 x service effective 01/01/2017 and to $170 x service effective 01/01/2019.
[3] Defined Dollar increases to $190 x service effective 01/01/2017 and to $225 x service effective 01/01/2019. Retiree who timely elects Defined Dollar and is otherwise eligible to contribute to an HSA is entitled to a one-time HSA contribution of $1,500 for retirements in 2015-2018 and $1,200 for retirements in 2019. The HSA employer contribution is subject to IRS limits on maximum annual contributions.

GAS-RR-024
Attachment B
Page 106 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
821A	Bay State Union Brockton Physical FT hired before 03/01/1991 and age 45 on 09/01/1991	PPO HD PPO 1 HD PPO 2 Tufts HMO	100% of premium
822	Bay State Union Brockton C/T FT and hired before 06/01/2013 and retired before 05/01/2013 and does not meet requirements of 822A	PPO HD PPO 1 HD PPO 2 Tufts HMO	Defined Dollar $180 x service retiree $125 x service spouse
822A	Bay State Union Brockton C/T FT hired before 10/01/1990 and age 45 by 01/01/1992	PPO HD PPO 1 HD PPO 2 Tufts HMO	100% of premium
822Y13	Bay State Union Brockton C/T FT hired before 06/01/2013 and retired on or after 05/01/2013	PPO HD PPO 1 HD PPO 2 Tufts HMO	Defined Dollar $180 x service retiree $125 x service spouse
823	Bay State Union Granite FT retired after 01/01/2004	COBRA Active Medical	None
823A	Bay State Union Granite FT hired before 05/01/1991 and age 45 by 05/01/1991 and retired before 01/01/2004	PPO HD PPO 1 HD PPO 2 Anthem BCBS NH-ME HMO	100% of premium
824	Bay State Union Lawrence FT retired after 01/01/2004 and retired before 01/01/2013 and does not meet requirements of 824A	COBRA Active Medical	None
824A	Bay State Union Lawrence FT hired before 01/01/1994 and age 45 by 01/01/1994 and retired before 01/01/2013	PPO HD PPO 1 HD PPO 2 Tufts HMO	100% of premium
824Y13	Bay State Union Lawrence FT hired before 01/01/2013 retired on or after 01/01/2013	PPO HD PPO 1 HD PPO 2 Tufts HMO	Defined Dollar $180 x service retiree $125 x service spouse

GAS-RR-024
Attachment B
Page 107 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
825	Bay State Union Northhampton FT hired after 06/18/1999 but before 01/01/2011	COBRA Active Medical	None
825A	Bay State Union Northhampton FT hired before 06/18/1999 and at least age 45 on 01/01/1993	PPO HD PPO 1 HD PPO 2 Health New England HMO	100% of premium
825B	Bay State Union Northhampton FT hired before 06/18/1999 and not age 45 on 01/01/1993 and retired before 01/01/2013	PPO HD PPO 1 HD PPO 2 Health New England HMO	Up to $1,100 per month
825B13	Bay State Union Northhampton FT hired before 06/18/1999 and not age 45 on 01/01/1993 and retiring between 01/01/2013 and 12/31/2015	PPO HD PPO 1 HD PPO 2 Health New England HMO	Up to $1,100 per month
825B16	Bay State Union Northhampton FT hired before 06/18/1999 and not age 45 on 01/01/1993 and retiring on or after 01/01/2016	PPO HD PPO 1 HD PPO 2 Health New England HMO	Up to $1,100 per month
826	Bay State Union Portland FT retired after 01/01/2004 and does not meet requirements of 826A	COBRA Active Medical	None
826A	Bay State Union Portland FT hired before 04/01/1991 and age 45 by 04/01/1991	PPO HD PPO 1 HD PPO 2 Anthem BCBS NH-ME HMO	100% of premium
827	Bay State Union Portsmouth FT hired after 06/04/1999	COBRA Active Medical	None
827A	Bay State Union Portsmouth FT hired before 06/04/1999 and age 45 on 01/01/1993	PPO HD PPO 1 HD PPO 2 Anthem BCBS NH-ME HMO	100% of premium

GAS-RR-024
Attachment B
Page 108 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
827B	Bay State Union Portsmouth FT hired before 06/04/1999 and not age 45 on 01/01/1993	PPO HD PPO 1 HD PPO 2 Anthem BCBS NH-ME HMO	Up to $1,100 per month
828	Bay State Union Springfield Physical FT hired after 05/14/1999 and retired before 05/15/2013	COBRA Active Medical	None
828A	Bay State Union Springfield Physical FT hired before 05/14/1999 and at least age 45 on 01/01/1993	PPO HD PPO 1 HD PPO 2 Health New England HMO	100% of premium
828B	Bay State Union Springfield Physical FT hired before 05/14/1999 and not age 45 on 01/01/1993 and retired before 05/15/2013	PPO HD PPO 1 HD PPO 2 Health New England HMO	Up to $1,100 per month
828B13	Bay State Union Springfield Physical FT hired before 05/14/1999 and not age 45 on 01/01/1993 and retired between 05/15/2013 and 12/31/2013	PPO HD PPO 1 HD PPO 2 Health New England HMO	Up to $1,100 per month
828B14	Bay State Union Springfield Physical FT hired before 05/14/1999 and not age 45 on 01/01/1993 and retired on or after 01/01/2014	PPO HD PPO 1 HD PPO 2 Health New England HMO	Up to $1,100 per month
828Y13	Bay State Union Springfield Physical FT hired after 05/14/1999 and before 01/01/2014 and retired on or after 05/15/2013	COBRA Active Medical	None
829	Bay State Union Springfield C/T FT retired after 01/01/2004 and retired on or before 01/01/2008 and does not meet the requirements of 829A	COBRA Active Medical	None

GAS-RR-024
Attachment B
Page 109 of 111

Retiree Benefit Program (RBP)	Group	Pre-Medicare Medical Options	Company Subsidy
829A	Bay State Union Springfield C/T FT hired before 10/01/1990 and age 45 by 01/01/1992	PPO HD PPO 1 HD PPO 2 Health New England HMO Tufts HMO	100% of premium
829Y08	Bay State Union Springfield C/T FT retired after 01/01/2008 and retired before 01/01/2011 and does not meet the requirements of 829A	PPO HD PPO 1 HD PPO 2 Health New England HMO Tufts HMO	Defined Dollar $180 x service retiree[1] $125 x service spouse[2]
829Y11	Bay State Union Springfield C/T FT hired before 01/01/2011 and retired between 01/01/2011 and 12/31/2015 and does not meet the requirements of 829A	PPO HD PPO 1 HD PPO 2 Health New England HMO Tufts HMO	Defined Dollar $180 x service retiree[1] $125 x service spouse[2]
829Y16	Bay State Union Springfield C/T FT hired before 01/01/2011 and retired on or after 01/01/2016 and does not meet the requirements of 829Y11	PPO HD PPO 1 HD PPO 2 Health New England HMO Tufts HMO	Defined Dollar $180 x service retiree[1] $125 x service spouse[2]

[1] Defined Dollar increases to $190 x service effective 01/01/2018 and to $225 x service effective 01/01/2019.
[2] Defined Dollar increases to $135 x service effective 01/01/2018 and to $170 x service effective 01/01/2019.

GAS-RR-024
Attachment B
Page 110 of 111

Active Programs That Will Not Receive Retiree Benefits

Active Benefit Program	Group
106	All Nonunion Exempt FT hired after 01/01/2010
107	All Nonunion Exempt PT hired after 01/01/2010
108	All Nonunion Non-Exempt FT hired on or after 01/01/2013
109	All Nonunion Non-Exempt PT hired on or after 01/01/2013
222	NIPSCO Union PT
223	NIPSCO Union TMP
224	NIPSCO Union TWF
623	CEG Union FT hired on or after 01/01/2013
624	CEG Union PT hired on or after 01/01/2013
830	Bay State Union Springfield C/T PT hired before 01/01/2011
831	Bay State Union Brockton Physical FT hired on or after 01/01/2013
832	Bay State Union Brockton C/T FT hired on or after 06/01/2013 and retired after 05/01/2013
834	Bay State Union Brockton Physical PT hired before 01/01/2013
835	Bay State Union Northhampton FT hired on or after 01/01/2011
838	Bay State Union Springfield Physical FT hired on or after 01/01/2014
839	Bay State Union Springfield C/T FT hired on or after 01/01/2011
840	Bay State Union Springfield C/T PT hired on or after 01/01/2011
844	Bay State Union Brockton Physical PT hired on or after 01/01/2013
854	Bay State Union Lawrence FT hired on or after 01/01/2013

COLUMBIA ENERGY GROUP PENSION PLAN

Amended and Restated effective as of January 1, 2014

December 2014

Table of Contents

Page

ARTICLE I DEFINITIONS AND CONSTRUCTION 1
1.01 AB I Account 1
1.02 AB I Benefit 1
1.03 AB I Participant 1
1.04 AB II Account 1
1.05 AB II Benefit 1
1.06 AB II Participant 1
1.07 Accrued Benefit 1
1.08 Actuarial Equivalent 1
1.09 Authorized Leave of Absence 3
1.10 Beneficiary 3
1.11 Benefit Commencement Date 3
1.12 Break in Service 4
1.13 Child/Children 4
1.14 Code 4
1.15 Committee 4
1.16 Company 4
1.17 Compensation 4
1.18 Conversion Date 6
1.19 Credited Service 7
1.20 Disability/Disabled 7
1.21 Early Retirement Age 7
1.22 Early Retirement Date 7
1.23 Effective Date 8
1.24 Eligible Employee 8
1.25 Employee 8
1.26 Employer 8
1.27 ERISA 9
1.28 Exempt Employee 9
1.29 FAP Benefit 9
1.30 FAP Participant 9
1.31 Final Average Pay 9
1.32 Highly Compensated Employee 9
1.33 Hour of Service 9
1.34 Interest Credits 10
1.35 Late Retirement Date 10
1.36 Leased Employee 10
1.37 Next Gen Employee 10
1.38 NiSource. 10
1.39 Non-Exempt Employee 10
1.40 Normal Retirement Age 10
1.41 Normal Retirement Date 11
1.42 Opening Balance 11
1.43 Participant 11
1.44 Pay-Based Credits 11
1.45 Plan 11
1.46 Plan 2006 Restatement. 11

Table of Contents

Page

1.47 Plan Administrator 11
1.48 Plan Sponsor 11
1.49 Plan Year 11
1.50 Point Service 11
1.51 Protected Benefit 11
1.52 Related Employer 11
1.53 Severance from Service. 12
1.54 Single Life Annuity 12
1.55 Social Security Retirement Age 12
1.56 Spouse 12
1.57 Taxable Wage Base 12
1.58 Termination of Service 12
1.59 Treasury Regulations 12
1.60 Trust 12
1.61 Trust Agreement 12
1.62 Trustee 12
1.63 Union Employee 12
1.64 Vested/Nonforfeitable 12
1.65 Vesting Service 12
1.66 Terms Defined Elsewhere 12

ARTICLE II SERVICE PROVISIONS 14
2.01 Vesting Service 14
2.02 Credited Service 14
2.03 Point Service 15
2.04 Special Service Rules 16
2.05 Severance from Service 18
2.06 Break in Service 18

ARTICLE III PARTICIPATION AND TRANSFERS 20
3.01 Date of Participation 20
3.02 Participation Upon Reemployment 20
3.03 Continuation of Participation 20
3.04 Transfers 20
3.05 Conditions of Participation 23

ARTICLE IV AB II BENEFIT 24
4.01 Applicability of Article 24
4.02 AB II Benefit 24
4.03 AB II Account 25
4.04 Pay-Based Credits 26
4.05 Interest Credits 27
4.06 Protected Benefit for AB II Participant 28
4.07 Transition of All Participants to the AB II Benefit 28

ARTICLE V AB I BENEFIT 30
5.01 Applicability of Article 30
5.02 AB I Benefit 31

Table of Contents

Page

5.03 AB I Account 31
5.04 Pay-Based Credits 32
5.05 Interest Credits 32
5.06 Protected Benefit for an AB I Participant 33

ARTICLE VI FAP BENEFIT 34
6.01 Applicability of Article 34
6.02 FAP Benefit 34
6.03 Supplemental Retirement Income 35

ARTICLE VII RETIREMENT BENEFITS 36
7.01 Normal Retirement Benefit 36
7.02 Late Retirement Benefit 36
7.03 Early Retirement Benefit 37
7.04 Disability Benefit 37
7.05 Nonduplication of Benefits 38

ARTICLE VIII TERMINATION OF SERVICE; PARTICIPANT VESTING 39
8.01 Termination of Service Prior to Normal or Early Retirement or Death 39
8.02 Vesting 40
8.03 Included Years of Vesting Service 40
8.04 Deemed Cash-Out Provision for Non-Vested Participants 40

ARTICLE IX DEATH BENEFITS 41
9.01 Death On Or After Benefit Commencement Date 41
9.02 Death Prior to Benefit Commencement Date 41
9.03 Additional Death Benefit Payment Provisions 43
9.04 Preretirement Survivor Annuity Requirements 44
9.05 Beneficiary Designation 45
9.06 Failure of Beneficiary Designation 45
9.07 Facility of Payment 46

ARTICLE X TIME AND METHOD OF PAYMENT OF BENEFITS 47
10.01 Automatic Form of Benefit Payment 47
10.02 Waiver Election - Qualified Joint And Survivor Annuity 47
10.03 Optional Forms of Benefit Distribution 48
10.04 Cash Out of Small Amounts 49
10.05 Claim for Benefits 50
10.06 Restrictions on Distribution Timing 50
10.07 Minimum Distribution Requirements 50
10.08 Purchase Of Nontransferable Annuity 56
10.09 Qualified Domestic Relations Order 57
10.10 Direct Rollovers 58
10.11 True-Up Amounts 59
10.12 Retroactive Annuity Starting Date 59

ARTICLE XI SUSPENSION OF BENEFITS UPON CERTAIN EMPLOYMENT OR REEMPLOYMENT 62

Table of Contents

Page

11.01 Suspension of Benefits 62
11.02 Benefits Upon Reemployment 62
11.03 Suspension of Benefits Notice 64

ARTICLE XII CONTRIBUTIONS 65
12.01 Employer Contributions 65
12.02 Determination of Employer Contribution 65
12.03 Time of Payment of Employer Contribution 65
12.04 Return of Employer Contributions 65
12.05 Application of Forfeitures 65
12.06 Employee Contributions 65

ARTICLE XIII LIMITATION ON BENEFITS 66
13.01 Effective Date 66
13.02 Annual Benefit 66
13.03 Other Defined Benefit Plans 66
13.04 Grandfather Provision 66
13.05 Coordination with Other Rules 66
13.06 Definitions 66
13.07 Other Rules 74

ARTICLE XIV EMPLOYER ADMINISTRATIVE PROVISIONS 76
14.01 Information To Plan Administrator 76
14.02 No Liability 76
14.03 Indemnity Of Committee 76

ARTICLE XV PARTICIPANT ADMINISTRATIVE PROVISIONS 77
15.01 Personal Data To Plan Administrator 77
15.02 Address For Notification 77
15.03 Notice Of Change In Terms 77
15.04 Assignment Or Alienation 77
15.05 Litigation Against The Plan 77
15.06 Information Available 77
15.07 Presenting Claims For Benefits 77
15.08 Claims Review Procedure 78
15.09 Disputed Benefits 79

ARTICLE XVI ADMINISTRATION 80
16.01 Allocation Of Responsibility Among Fiduciaries For Plan And Trust Administration 80
16.02 Appointment Of Committee 80
16.03 Committee Procedures 80
16.04 Other Committee Powers And Duties 80
16.05 Records And Reports 81
16.06 Rules And Decisions 81
16.07 Application And Forms For Benefits 82
16.08 Authorization Of Benefit Payments 82
16.09 Funding Policy 82

Table of Contents

Page

16.10 Unclaimed Accrued Benefit – Procedure 82
16.11 Fiduciary Duties 82
16.12 Allocation Or Delegation Of Duties And Responsibilities 82
16.13 Procedure For The Allocation Or Delegation Of Fiduciary Duties 83
16.14 Individual Statement 83
16.15 Recovery of Overpaid Benefits 83

ARTICLE XVII TRUST FUND 84
17.01 Establishment Of Trust 84
17.02 Investment Of Trust Assets 84
17.03 Fees And Expenses From Trust 84
17.04 Distribution Directions 84
17.05 Trust For Exclusive Benefit Of Participants Of The Plan And Their Beneficiaries 84

ARTICLE XVIII MEDICAL BENEFITS ACCOUNT 85
18.01 Purpose 85
18.02 Eligibility for Medical Benefits 85
18.03 Right to Change Medical Benefits 85
18.04 Funding and Subordination of Medical Benefits 85
18.05 Separate Account 86
18.06 Separate Account Assets 86
18.07 Forfeitures 87

ARTICLE XIX TOP HEAVY PROVISIONS 88
19.01 Minimum Benefit 88
19.02 Determination Of Top Heavy Status 88
19.03 Definitions 89
19.04 Application of Article 90

ARTICLE XX MISCELLANEOUS 91
20.01 Evidence 91
20.02 No Responsibility For Employer Action 91
20.03 Fiduciaries Not Insurers 91
20.04 Waiver Of Notice 91
20.05 Successors 91
20.06 Word Usage 91
20.07 Headings 91
20.08 Governing Law and Venue 91
20.09 Employment Not Guaranteed 92

ARTICLE XXI EXCLUSIVE BENEFIT; AMENDMENT; TERMINATION 93
21.01 Exclusive Benefit 93
21.02 Amendment To Plan or Trust 93
21.03 Amendment To Vesting Provisions 93
21.04 Merger/Direct Transfers And Elective Transfers 94
21.05 Discontinuance 94
21.06 Full Vesting On Termination 95

Table of Contents

Page

21.07 Partial Termination 95
21.08 Termination 95
21.09 Distribution Upon Termination Of Trust Fund 95
21.10 Manner Of Distribution 96
21.11 Overfunding 96
21.12 Special Restriction On Benefit 96

SCHEDULE I – LIST OF PARTICIPATING EMPLOYERS 98

SCHEDULE II – CASH BALANCE ELECTION PERIODS 99

SCHEDULE III –BENEFIT RESTRICTIONS PURSUANT TO CODE SECTION 436 103

APPENDIX A -- TCO VOLUNTARY INCENTIVE RETIREMENT PROGRAM 111

APPENDIX B -- CDC/CS VOLUNTARY INCENTIVE RETIREMENT PROGRAM 114

APPENDIX C -- JANUARY 2001 VOLUNTARY EARLY RETIREMENT PROGRAM 118

APPENDIX D -- 2002 WORKFORCE REDUCTION WINDOW 121

COLUMBIA ENERGY GROUP PENSION PLAN

NiSource Inc. ("NiSource") maintains the Columbia Energy Group Pension Plan (f/k/a/ the Retirement Plan of Columbia Energy Group Companies) (the "Plan") for the benefit of Eligible Employees of NiSource's subsidiary, Columbia Energy Group (the "Company" and "Plan Sponsor") and any other Related Employer that adopts the Plan. The Plan is hereby amended and restated in its entirety effective as of January 1, 2014, and such other dates set forth herein.

Purpose

The Plan Sponsor established the Plan to provide for a portion of the livelihood of Participants and their beneficiaries in their retirement. The Plan and the related Trust are intended to meet the requirements of Section 401(a) and Section 501(a) of the Internal Revenue Code of 1986, as amended (the "Code"), and all other applicable statutory and regulatory requirements.

Special effective dates are included with respect to a number of provisions as necessary to conform to various legislation and guidance (including but not limited to): the Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA") (as such provisions were previously adopted and reflected in a restated plan document effective January 1, 2006 (the "Plan 2006 Restatement")); revisions required to comply with Code Section 415 (as such provisions were previously adopted by the Company in a separate Plan amendment); and changes to comply with the Pension Protection Act of 2006 ("PPA"). The NiSource Benefits Committee (the "Committee") amended and restated the Plan effective as of January 1, 2009 to reflect various design changes and to update the Plan in accordance with the legislative changes referenced above (the "Plan 2009 Restatement"). The Plan 2009 Restatement also reflected a change in the name of the Plan from the "Retirement Plan of Columbia Energy Group Companies" to the "Columbia Energy Group Pension Plan" effective January 1, 2010. The Committee further amended and restated the Plan effective as of January 1, 2010 (the "Plan 2010 Restatement"), effective as of January 1, 2011 (the "Plan 2011 Restatement"), and effective as of January 1, 2013 (the "Plan 2013 Restatement"), in each instance to make certain clarifications with respect to the administration and operation of the Plan. Further, the Plan 2013 Restatement amended the Plan so as to provide that any Non-Exempt Employee hired or rehired on or after January 1, 2013 is no longer eligible to participate in the Plan. The Committee now amends and restates the Plan effective as of January 1, 2014 (and such other dates set forth herein) to make additional clarifications with respect to the administration and operation of the Plan (the "Plan 2014 Restatement").

The provisions of this amended and restated Plan shall apply solely to an Employee whose employment with the Employer terminates on or after the Effective Date (or with respect to the application of a specific Plan provision containing a different effective date, then such provision shall apply to an Employee who terminates on or after such effective date). An Employee whose employment with the Employer terminates prior to the Effective Date shall be entitled to a benefit, if any, as determined under the provisions of the Plan in effect on the date that his employment terminated.

Plan Background

Formerly known as the "Retirement Income Plan for Columbia Energy Group Companies," the Plan originally was established effective January 1, 1943. The Plan has been amended and restated several times, including a Plan restatement effective as of January 1, 2004 to provide for the election of the cash balance feature for certain union employees. In the Plan 2006 Restatement, the Plan was further amended and restated to provide for the election of an additional cash balance feature for exempt employees effective January 1, 2006.

Since the Plan 2006 Restatement, and as reflected in the Plan 2009 Restatement, the Plan 2010 Restatement, the Plan 2011 Restatement, and the Plan 2013 Restatement, the Plan was further amended to comply with certain legally-required changes and to reflect other design revisions, including the following: (1) providing that all Eligible Employees hired on or after January 1, 2008 (but before January 1, 2010, with respect to Exempt Employees) participate in the cash balance feature of the Plan referred to as the AB II Benefit (f/k/a Account Balance 2011 Option Benefit) as described in Article IV; (2) providing that all active Exempt Employees shall be subject to the AB II Benefit provisions described in Article IV on and after January 1, 2011 and that all Disabled Exempt Employees shall be subject to the AB II Benefit provisions described in Article IV on and after January 1, 2012; (3) providing that all Non-Exempt Employees shall be subject to the AB II Benefit provisions described in Article IV on and after January 1, 2013; and (4) providing that any Non-Exempt Employee hired or rehired on or after January 1, 2013 is no longer eligible to participate in the Plan. Certain terminated or non-active Participants continue to be subject to the Plan provisions providing for an AB I Benefit (f/k/a Account Balance Option Benefit) as described in Article V, or the Plan provisions providing for a FAP Benefit (f/k/a Final Pay Option Benefit) as described in Article VI. Appendices attached hereto describe the features of certain voluntary incentive and early retirement window programs.

ARTICLE I

DEFINITIONS AND CONSTRUCTION

As used herein, unless otherwise defined or required by the context, the following words and phrases shall have the meanings indicated. Some of the words and phrases used in the Plan are not defined in this Article I, but for convenience are defined as they are introduced into the text. The location of such terms is set forth at the end of this Article.

Whenever appropriate, words and terms defined in the singular may be read as the plural, and the plural may be read as the singular. Unless otherwise required by the context, masculine pronouns also shall include the feminine, and the feminine shall include the masculine. The headings of Articles and Sections are included solely for convenience, and if there is any conflict between such headings and the text of the Plan, the text shall control.

1.01 AB I Account. The bookkeeping account, the amount of which is determined in accordance with Section 5.03, from which a Participant's AB I Benefit is derived.

1.02 AB I Benefit. The portion of a Participant's Accrued Benefit that accrues in accordance with Section 5.02.

1.03 AB I Participant. A Participant who is accruing an AB I Benefit pursuant to Article V.

1.04 AB II Account. The bookkeeping account, the amount of which is determined in accordance with Section 4.03, from which a Participant's AB II Benefit is derived.

1.05 AB II Benefit The portion of a Participant's Accrued Benefit that accrues in accordance with Section 4.02.

1.06 AB II Participant. A Participant who is accruing an AB II Benefit pursuant to Article IV.

1.07 Accrued Benefit. As of any given date, the monthly benefit determined in accordance with Section 4.02 (with respect to any AB II Participant), Section 5.02 (with respect to any AB I Participant) or Section 6.02 (with respect to any FAP Participant), as applicable, payable in the form of a Single Life Annuity commencing at Normal Retirement Date, or, if applicable, at Late Retirement Date, and considering as of the date of determination either the Participant's AB II Account or AB I Account (if applicable) or in the case of any FAP Participant, considering Credited Service and Final Average Pay. Notwithstanding the foregoing, however, a Participant's Accrued Benefit shall never be less than the Participant's Protected Benefit, if applicable. In addition, a Participant's Accrued Benefit shall be subject to any top heavy minimum benefit described in Article XIX.

Notwithstanding any provision of the Plan to the contrary (including the Plan provisions relating to Code Section 417(e)), with respect to any AB II or AB I Participant, effective with respect to distributions made on or after January 1, 2008, the present value of a Participant's Vested Accrued Benefit for purposes of making a distribution of a Participant's entire Vested Accrued Benefit (including for purposes of complying with the requirements of Code Section 417(e)), shall be equal to the Participant's AB II Account or AB I Account, as applicable, subject also to any applicable Protected Benefit provision.

1.08 Actuarial Equivalent. A benefit of equal value computed by using factors intended to produce equality in the value of the aggregate amounts expected to be received under different forms and/or timing of benefits. Such equivalent value is determined on the basis of the interest rate, mortality table and other factors, if any, applicable to such other annuity or benefit, as in effect at the date of determination as specified below.

(a) In General. Unless specified otherwise in the Plan, for purposes of determining the Actuarial Equivalent, the Plan shall apply the "Plan Interest Rate" and the "Plan Mortality Table" as set forth in this subsection (a), subject to the minimum benefit requirements set forth in subsection (c) below.

(i) "Plan Interest Rate" shall be the annual rate of interest on 30-year Treasury Securities, as determined and published by the Internal Revenue Service, determined each Plan Year using the interest rate in effect for the month of September immediately preceding the first day of the Plan Year containing the Benefit Commencement Date (or with respect to the calculation of Opening Balances, for the month of September immediately preceding the first day of the Plan Year containing the Conversion Date).

(ii) "Plan Mortality Table" shall be the mortality table prescribed by the Internal Revenue Service as set forth in Revenue Ruling 2001-62 (commonly referred to as the 1994 GAR Mortality Table).

(b) Applicability. Except as set forth in subsection (c) or (d) below or specifically stated otherwise in the Plan, the Plan Interest Rate and the Plan Mortality Table shall be used in computing an Actuarial Equivalent benefit for all purposes under the Plan, including: (i) calculating the lump sum present value of a Participant's Accrued Benefit; (ii) calculating the lump sum present value of a Participant's Protected Benefit; (iii) determining an Opening Balance pursuant to Section 4.03(b) or Section 5.03(b); or (iv) converting an AB I Account or AB II Account to a Single Life Annuity.

In addition, for purposes of calculating a FAP Benefit under Article VI or a Participant's Protected Benefit, if the Benefit Commencement Date precedes the date the Participant reaches age 55 (or would have attained age 55, in the case of a death benefit for a FAP Participant), the Plan shall calculate such benefit using the Plan Interest Rate and the Plan Mortality Table, applying such factors to the Normal Retirement Benefit. If the Benefit Commencement Date is on or after the date the Participant reaches age 55 (or would have attained age 55, in the case of a death benefit for a FAP Participant), the Plan shall apply the foregoing factors to the immediately payable benefit (or Protected Benefit), with such benefit calculated in accordance with any early retirement reduction factors set forth in the Plan. This benefit commencing on or after age 55 shall be no less than the Actuarial Equivalent present value of the benefit deferred to age 65, applying the Minimum Interest Rate and Minimum Mortality Table (but not calculated as a deferred to 65 benefit applying the Plan Interest Rate and Plan Mortality Table).

(c) Minimum Calculation Provisions: Notwithstanding the foregoing, effective January 1, 2008, in accordance with the requirements of Code Section 417(e)(3), for purposes of calculating (i) the Actuarial Equivalent lump sum present value of a Participant's Accrued Benefit, (ii) the lump sum value of a Protected Benefit, or (iii) a Participant's Opening Balance, the Plan shall apply the Minimum Interest Rate and Minimum Mortality Table (defined herein) if such factors jointly produce a greater benefit than applying the Plan Interest Rate and Plan Mortality Table.

(i) "Minimum Interest Rate" shall be the "applicable interest rate" under Code Section 417(e)(3)(C) (commonly referred to as the "Corporate Bond Rate"), which is the adjusted first, second, and third segment rates applied under rules similar to the rules of Code Section 430(h)(2)(C) (determined without regard to the 24-month averaging provided under Code Section 430(h)(2)(D)(i) and applying the 5-year transition phase-in rule of Code Section 417(e)(3)(D)(ii)), determined each Plan Year using the interest rates in effect for the month of September immediately preceding the first day of the Plan Year containing the Benefit Commencement Date (or with respect to the calculation of Opening Balances, for the month of September immediately preceding the Conversion Date).

(ii) "Minimum Mortality Table" shall be the mortality table under Code Section 417(e)(3) that is prescribed by the Internal Revenue Service as set forth in Revenue Ruling 2007-67 and by subsequent guidance issued by the Internal Revenue Service.

(d) Special Conversion Factors. When converting a Single Life Annuity or a lump sum benefit into another form of payment under the Plan (other than a Single Life Annuity or a lump sum), the Actuarial Equivalent interest rate used shall be 8% per year and the mortality table used shall be as follows: (i) for conversion of an AB II Benefit, the Plan uses the 1983 Group Annuity Mortality Table ("83 GAM"), based on a fixed blend of 50% male and 50% female; and (ii) for conversion of a FAP Benefit or an AB I Benefit, the Plan uses the 83 GAM, set back one year for Participants and set back five years for Beneficiaries.

(e) Effective January 1, 2008, a Participant's AB II Benefit equals his AB II Account. Prior to January 1, 2008, the lump sum Actuarial Equivalent of a Participant's AB II Benefit (which was expressed as a Single Life Annuity) was generally equal to his AB II Account, but in no event less than the Actuarial Equivalent of the AB II Benefit determined in accordance with subsection (a) above.

(f) Effective January 1, 2008, a Participant's AB I Benefit equals his AB I Account. Prior to January 1, 2008, the lump sum Actuarial Equivalent of a Participant's AB I Benefit (which was expressed as a Single Life Annuity) was generally equal to his AB I Account, but in no event less than the Actuarial Equivalent of the AB I Benefit determined in accordance with subsection (a) above.

1.09 Authorized Leave of Absence. Any absences (with or without Compensation) authorized by an Employer under the Employer's standard personnel practices, provided that all persons under similar circumstances must be treated alike in the granting of such Authorized Leaves of Absence, and provided further that the Participant returns within the period specified in the Authorized Leave of Absence. If a Participant does not resume work with the Employer, the date that the Authorized Leave of Absence ends shall be deemed the Participant's Termination of Service. An Authorized Leave of Absence shall include (i) a leave of absence authorized by an Employer pursuant to the provisions of the Family and Medical Leave Act and (ii) a leave of absence due to service in the Armed Forces of the United States to the extent required by Code Section 414(u)(effective with respect to re-employment initiated on or after December 12, 1994).

1.10 Beneficiary. The individual(s) or entity, determined pursuant to Section 9.05, who is or may become entitled to a benefit under the Plan. With respect to the death benefit of any FAP Participant, only a surviving Spouse or surviving Children under the age of 21 can be the Beneficiary under the Plan. A Beneficiary who becomes entitled to a benefit under the Plan is a Beneficiary under the Plan until such benefit is fully distributed. A Beneficiary's right to information concerning the Plan, and the Plan Administrator's, the Committee's or the Trustee's duty to provide to the Beneficiary information concerning the Plan, does not arise until the Beneficiary first becomes entitled to receive a benefit under the Plan.

1.11 Benefit Commencement Date. A term used in the calculation of a Participant's benefit under the Plan and which shall be the first day of the month for which the Plan pays a benefit pursuant to Article VII (*i.e.*, on the Normal Retirement Date, Early Retirement Date or Late Retirement Date) or Article VIII (*i.e.*, on the Vested Retirement Date). Notwithstanding the foregoing, prior to January 14, 2010, Benefit Commencement Date shall mean: for an annuity form of distribution, the first day of the first period for which the Plan pays an amount as an annuity; for a lump sum payment, the first day of the month next following the date on which all events have occurred that entitles the Participant to the benefit. For purposes of establishing a Benefit Commencement Date within a particular Plan Year (*i.e.*, establishing a Benefit Commencement Date of no later than December 1st of such Plan Year), a Participant must terminate employment on or before November 30 of that year and timely comply with all procedural requirements established by the Plan Administrator (*e.g.*, initiation or completion (as required by the Plan Administrator) of distribution forms, consents, etc.).

1.12 Break in Service. A period of absence from employment, as defined in Section 2.06.

1.13 Child/Children. The naturally born or legally adopted surviving child or children of a deceased Participant.

1.14 Code. The Internal Revenue Code of 1986, as amended from time to time.

1.15 Committee. The NiSource Benefits Committee, established and maintained pursuant to Article XVI to administer and amend the Plan.

1.16 Company. Columbia Energy Group, or any successor to it in the ownership of substantially all its assets.

1.17 Compensation. Except to the extent modified for specific Participant groups as set forth below, Compensation means the base pay received by an Employee from an Employer. In general, Compensation shall be determined on a monthly basis. For a full-time Employee who is paid on a monthly, semi-monthly, biweekly, or weekly basis, monthly Compensation shall equal one-twelfth of the Employee's annual base rate of pay last in effect for the month, plus pay inclusions set forth below such as actual commissions paid in the month. For part-time Employees, monthly Compensation shall equal the sum of the actual Compensation, plus pay inclusions set forth below (such as commissions) paid to the Employee for each pay period during the month.

Compensation shall include the following: (1) one-time payments in lieu of salary increases for any Plan Year (referred to as "lump-sum merit pay") (included effective September 1, 2009); (2) amounts deferred and excluded from the Participant's taxable income pursuant to Code Sections 125, 132(f)(4), 402(e)(3), or 402(h)(1)(B); (3) commissions (to the extent an Employee is compensated in whole or in part on a commission basis); and (4) solely with respect to Participants subject to the NiSource Vacation Policy ("Vacation Policy") and subject to any payment timing limitations set forth below, any amounts attributable to "banked" vacation (as that term is described in the Vacation Policy) during the calendar year including such Participant's Termination of Service. Effective January 1, 2009, for Participants on active duty in the uniformed services for a period of more than 30 days, Compensation shall include any differential wage payments, as defined by Code Section 3401(h)(2), to the extent such payments are made by the Employer. Such differential wage payments shall be treated as compensation for all Plan purposes, including Code Section 415 and any other Code section that references the definition of compensation under Code Section 415. A Participant receiving such differential wage payment shall be treated as an Employee of the Employer making the payment.

For purposes of the foregoing paragraph, "base pay" shall exclude various forms of compensation, including (but not limited to) the following: overtime, any amounts deferred to a nonqualified plan maintained by an Employer, and other special forms of compensation such as shift differential, call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income. Effective for limitations years beginning on or after July 1, 2007, for purposes of applying the limitations of Article XIII and to the extent otherwise included in Plan Compensation, Compensation generally shall exclude amounts paid after Termination of Service. However, Compensation shall include post-severance amounts set forth in items (i) and (ii) below to the extent such amounts are paid by the later of 2 ½ months after Termination of Service or by the end of the Plan Year (the Limitation Year for purposes of Article XIII) that includes the date of such Termination of Service. Provided the foregoing timing-of-payment condition is met, Compensation shall include:

(i) Regular pay paid after Termination of Service if: (a) the payment is regular compensation for services during the Participant's regular working hours, commissions, bonuses (to the extent included in Compensation by specific group), or other similar payments; and (b) the payment would have been paid to the Employee prior to a Termination of Service if the Employee had continued in employment with the Employer; and

(ii) To the extent otherwise included in Plan Compensation as described in this Section 1.17, payments of unused accrued bona fide sick, vacation, or other leave (but only if the Employee would have been able to use the leave if employment had continued).

In clarification of the foregoing, Compensation excludes any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance-based pay) when paid in any month following Termination of Service.

(a) Considerations by Specific Group. Subject to any limitations imposed by Code Section 415 as set forth in this Section, the following additional provisions regarding Compensation shall apply:

(i) AB II or AB I Participants. For any AB II Participant or AB I Participant, the definition of Compensation set forth above shall apply with the following modifications: (1) Compensation shall exclude unused and accrued vacation paid on or after Termination of Service, and (2) Compensation shall also include performance-based pay received by an Employee from an Employer. For purposes of determining a Participant's Pay-Based Credits under Sections 4.04 or 5.04, Compensation means the sum of the monthly Compensation for each month during the Plan Year in which the Participant is an AB II Participant or AB I Participant, including actual bonuses received by the Employee while actively employed in the month.

(ii) Compensation Crediting During Disability, Authorized Leave of Absence, or Other Absence. If an Employee who is participating in the Plan is absent from employment due to Disability, an Authorized Leave of Absence (during which time Compensation shall be credited for up to 12 months), or other approved absence for which service credit is given in accordance with Section 2.04(c) (during which time Compensation shall be credited for up to 12 months) (each individually referred to as "Employment Absence"), the Employee shall be deemed to receive Compensation during the period beginning on the date when he incurs an Employment Absence and ending on the earliest of the date on which the Employee's Employment Absence ends, the Employee is deemed to have a Severance from Service, or his Benefit Commencement Date. The Employee's Compensation for each month during this period shall equal one-twelfth of the Employee's annual base rate of pay last in effect for the month in which the Employment Absence occurred. In addition, solely for the month in which the Employment Absence began, Compensation shall include any other Plan Compensation inclusions generally if received in the month the Employment Absence began. For example, if a Participant receives incentive payments during the month in which an Employment Absence began, such amounts shall be included in the Participant's Compensation (if otherwise included in Plan Compensation) in the month received, but shall not otherwise affect the rate of Compensation crediting during the period of Employment Absence.

(b) Compensation Limit. In addition to other applicable limitations set forth in the Plan, and notwithstanding any other provisions of the Plan to the contrary, the annual Compensation of each Employee taken into account under the Plan shall not exceed the "Compensation Limit." The Compensation Limit for 2014 is $260,000, and is subject to cost of living adjustments in subsequent years in accordance with Code Section 401(a)(17)(B). Any such cost of living adjustment in effect for a calendar year applies to any period, not exceeding 12 months, over which Compensation is determined (the "Determination Period") beginning in such calendar year. If a Determination Period consists of fewer than 12 months, the Compensation Limit will be multiplied by a fraction, the numerator of which is the number of months in the Determination Period, and the denominator of which is 12. If Compensation for any prior Determination Period is taken into account in determining an Employee's benefits accruing in the current Plan Year, the Compensation for that prior

Determination Period is subject to the Compensation Limit in effect for that prior Determination Period. Any reference in this Plan to the limitation under Section 401(a)(17) of the Code shall mean the Compensation Limit set forth in this provision. Effective January 1, 2009, the Compensation Limit and the Determination Period are generally determined on an annual basis in accordance with the foregoing provisions. Prior to January 1, 2009, the Compensation Limit was applied on a monthly basis and in accordance with the provisions set forth in the Plan 2006 Restatement.

(c) Compensation – Special Rules. For purposes of Article XIII (Code Section 415 limits), the Employer shall apply the definition of Compensation set forth 13.06. For purposes of Article XIX (top heavy) and for determining whether the Plan discriminates in favor of Highly Compensated Employees, the Employer may elect to use an alternate nondiscriminatory definition of Compensation, in accordance with the requirements of Code Section 414(s) and the Treasury Regulations promulgated thereunder. In determining Compensation (for purposes of determining whether the Plan discriminates in favor of Highly Compensated Employees), the Employer may elect to include as Compensation all Elective Contributions (as defined in Code Section 415(c)(3)(D)(i) and (ii)) made by the Employer on behalf of Employees. The Employer's election to include Elective Contributions must be consistent and uniform with respect to Employees and all plans of the Employer for any particular Plan Year. The Employer may make this election to include Elective Contributions for nondiscrimination testing purposes, irrespective of whether Elective Contributions are included in the general definition of Compensation applicable to the Plan.

1.18 Conversion Date. The date on which a Participant transitions from a prior benefit structure under the Plan and begins to accrue an AB II Benefit under Section 4.02 or an AB I Benefit under Section 5.02, as applicable. Notwithstanding the foregoing, as set forth in Schedule II or as provided in a prior restatement for the Plan, during the period a Participant can elect to convert to the AB II Benefit or AB I Benefit, the benefit accrual period for the FAP Benefit (for purposes of calculating the Protected Benefit) may continue through the end of the election period or as otherwise specified. Accordingly, for purposes of calculating the Opening Balance and for crediting Pay-Based Credits and Interest Credits, the Conversion Date is the date the Participant becomes an AB II or AB I Participant (which may be an effective date occurring prior to the end of a cash balance election period). For purposes of calculating the Protected Benefit, the Conversion Date is the date that FAP Benefit accruals cease.

Accordingly, by way of example, but not limited hereto, the following Conversion Dates apply:

(a) In the case of a Participant who elects either the AB I Benefit or the AB II Benefit, as applicable, pursuant to the cash balance election periods described in Schedule II, the Conversion Date shall be as set forth in the applicable subsection of such Schedule.

(b) In the case of a Participant who transfers employment as set forth in Section 3.04 and becomes subject to the AB II Benefit provisions pursuant to the provisions of such Section 3.04, the Conversion Date for purposes of calculating such Participant's Opening Balance shall be the first day of the month coincident with or next following the date of his change in employment status.

(c) In the case of a Participant who terminates employment, is rehired as an Eligible Employee, and who becomes an AB II Participant in accordance with the provision of Section 11.02, the Conversion Date for purposes of calculating the Participant's Opening Balance is the first day of the month coincident with or next following the date of his return to active employment. (Notwithstanding the foregoing, for Exempt Employees rehired prior to May 1, 2007 and terminating prior to January 1, 2011, no Opening Balance was created but instead the FAP Benefit was frozen and paid as part of the Participant's Accrued Benefit.)

(d) In the case of an Exempt Employee participating in the Plan on January 1, 2011, who becomes an AB II Participant pursuant to Section 4.01(a)(iii) and Section 4.07, the Conversion Date is January 1, 2011 (December 31, 2010 for purposes of calculating the Protected Benefit).

(e) In accordance with Section 4.07, in the case of any frozen prior benefit of any active Exempt Employee accruing a benefit under the Plan on or after January 1, 2011, the Conversion Date for any previously accrued frozen FAP Benefit is as follows:

(i) With respect to any active Exempt Employee accruing a benefit under the Plan on January 1, 2011, the Conversion Date is January 1, 2011; or

(ii) With respect to any Participant who becomes an active Exempt Employee accruing a benefit under the Plan after January 1, 2011, the Conversion Date is the date such Participant becomes an active Exempt Employee accruing a benefit under the Plan.

(f) In the case of a Disabled Exempt Employee participating in the Plan on January 1, 2012, who becomes an AB II Participant pursuant to Section 4.01(a)(iii)(D) and Section 4.07, the Conversion Date is January 1, 2012 (December 31, 2011 for purposes of calculating the Protected Benefit).

(g) In the case of a Non-Exempt Employee (including any Disabled Non-Exempt Employee) participating in the Plan on January 1, 2013, who becomes an AB II Participant pursuant to Section 4.01(a)(ii) and Section 4.07, the Conversion Date is January 1, 2013 (December 31, 2012 for purposes of calculating the Protected Benefit).

(h) In accordance with Section 4.07, in the case of any frozen prior benefit of any active Non-Exempt Employee accruing a benefit under the Plan on or after January 1, 2013, the Conversion Date for any previously accrued frozen FAP Benefit is as follows:

(i) With respect to any active Non-Exempt Employee accruing a benefit under the Plan on January 1, 2013, the Conversion Date is January 1, 2013; or

(ii) With respect to any Participant who becomes an active Non-Exempt Employee accruing a benefit under the Plan after January 1, 2013, the Conversion Date is the date such Participant becomes an active Non-Exempt Employee accruing a benefit under the Plan

1.19 Credited Service. "Credited Service" means a period of employment used to determine the amount of a Participant's FAP Benefit, as defined in Section 2.02.

1.20 Disability/Disabled. Any physical or mental condition of an Employee that constitutes a disability under the long-term disability plan maintained by an Employer. A Disability commences when the Employee first qualifies for benefits under the Employer's long-term disability plan and ceases when the Employee no longer qualifies for benefits under such plan.

1.21 Early Retirement Age. A Participant's age prior to Normal Retirement Age when the Participant either:

(a) has attained at least age 60 and completed at least five years of Credited Service; or

(b) has attained at least age 55 and completed at least ten years of Credited Service.

1.22 Early Retirement Date. The first day of the month following a Participant's Termination of Service on or after his Early Retirement Age, but before his Normal Retirement Age. Notwithstanding the preceding sentence,

the Participant may elect as an Early Retirement Date the first day of any month following a Termination of Service after his Early Retirement Age, but not later than the first day of the month coinciding with or next following his Normal Retirement Age.

1.23 Effective Date. January 1, 2014, the date on which the provisions of this amended and restated Plan become effective, except as otherwise provided herein. The original Effective Date of the Plan was January 1, 1943.

1.24 Eligible Employee. Any Employee employed by the Employer other than the following:

(a) Any Next Gen Employee;

(b) an intern;

(c) any person who is covered by a collective bargaining agreement with an Employer which does not provide for participation in this Plan;

(d) any "Leased Employee" or any independent contractor (as determined by the Employer pursuant to its established payroll practices), regardless of whether a government agency, court or other entity subsequently determines such individual to be an employee); and

(e) any person employed by a Related Employer which has not adopted this Plan.

1.25 Employee. Any person who, on or after the Effective Date, is receiving remuneration for personal services rendered to an Employer (or any other Related Employer required to be aggregated with the Employer under Code Sections 414(b), (c), (m) or (o)). An Employee shall also include any individual on an Authorized Leave of Absence, and to the extent required by Code Section 414(n), any Leased Employee. Directors acting solely in that capacity shall not be considered an Employee. Moreover, an Employee shall not include an individual providing services to an Employer as an "independent contractor" (e.g., a person (who is not considered to be a Leased Employee) who is engaged as an independent contractor pursuant to a contract or agreement between such person and an Employer which designates him as an independent contractor or otherwise contemplates or implies that he shall function as an independent contractor). Only individuals who are paid as employees from an Employer payroll and treated by an Employer at all times as Employees shall be deemed Employees for purposes of the Plan. No independent contractor shall be treated as an Employee under the Plan during the period he renders services to an Employer as an independent contractor.

If the Employer does not characterize a person as an Employee and the Employer is later required to re-characterize such person's status with the Employer as an Employee, the person will be treated as an Employee under the Plan as of the date of the re-characterization, unless an earlier date is necessary to preserve the tax-qualified status of the Plan. Notwithstanding such general re-characterization, such person shall not be considered an "Eligible Employee" for purposes of Plan participation, except and to the extent necessary to preserve the tax-qualified status of the Plan.

1.26 Employer. The Company and any Related Employers that shall ratify and adopt this Plan in a manner satisfactory to, and with the consent of, the Committee; any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. Employers participating in the Plan shall be listed on Schedule I (attached hereto for informational purposes only and not formally part of the Plan). Unless otherwise provided by the Committee, an Employer participating in the Plan shall automatically cease to participate in the Plan on the date that such entity is no longer considered a Related Employer of the Company, and any employee of such Employer shall cease to accrue a benefit under the Plan as of such date. The Company and any applicable Related Employer may limit or extend the adoption of the Plan and the Trust Agreement to one or more groups of Employees and/or divisions, locations or operations.

1.27 ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

1.28 Exempt Employee. An Eligible Employee who is classified as an exempt employee under the payroll practices of an Employer.

1.29 FAP Benefit. The portion of a Participant's Accrued Benefit that accrues in accordance with Section 6.02.

1.30 FAP Participant. A Participant who is accruing a FAP Benefit under Article VI.

1.31 Final Average Pay.

(a) General Rule. Final Average Pay means one third of the total Compensation paid to a Participant for the 36 months while he is a FAP Participant during which he received the largest total Compensation, selected from the 60 months immediately preceding the earlier of the Participant's Termination of Service or Conversion Date. Periods of Service before and after a break in employment shall be considered consecutive for purposes of determining the 60-month period.

(b) Fewer Than 36 Months of Compensation. If a Participant does not receive Compensation during 36 months out of the 60-month period identified in subsection (a), Final Average Pay shall be determined over the total number of months within such 60-month period.

For purposes of determining the 36 months of largest total Compensation, such months do not have to be consecutive. Further, the Compensation Limit set forth under Section 1.17(b) shall be applied after determining the 36 months of largest total Compensation.

1.32 Highly Compensated Employee. For a particular Plan Year, any Employee who:

(a) at any time during the Plan Year or the prior Plan Year was a five (5)-percent owner (as defined in Section 416(i)(1) of the Code); or

(b) for the preceding Plan Year:

(i) received more than $115,000 in Compensation from the Employer (or such higher amount as adjusted for the cost of living pursuant to Code Section 414(q)(1)), and

(ii) was in the top twenty percent (20%) of Employees when ranked on the basis of Compensation paid during such Plan Year (excluding Employees described in Code Section 414(q)(5) and applicable regulations).

Highly Compensated Employees also include highly compensated former employees. A highly compensated former employee includes any Employee who has separated from Service (or was deemed to have separated from Service) prior to the current or preceding Plan Year, performs no Service for the Employer during such Plan Year, and was a highly compensated active Employee for either the separation year or any Plan Year ending on or after the Employee's 55th birthday in accordance with the rules for determining Highly Compensated Employee status in effect for that determination year and in accordance with applicable Treasury Regulations and IRS guidance.

1.33 Hour of Service. Each hour for which the Employee is paid or entitled to payment for the performance of duties for the Company or any Related Employer. Hours of Service shall be credited in accordance with Department of Labor Regulation Section 2530.200b-2.

1.34 Interest Credits. The amounts credited to a Participant's AB II Account or AB I Account in accordance with Section 4.05 or Section 5.05 respectively.

1.35 Late Retirement Date. For a Participant who remains or becomes employed as an Employee after his Normal Retirement Date, the first day of the month following his Termination of Service.

1.36 Leased Employee. Any person (other than an employee of the Employer) who, pursuant to an agreement between the Employer and the leasing organization, has provided services for the Employer (or for the Employer and related persons determined in accordance with Code Section 414(n)(6)) under the primary direction or control of the Employer on a substantially full-time basis for a period of at least one year. Contributions or benefits provided to a Leased Employee by the leasing organization which are attributable to services performed for the Employer shall be treated as being provided by the Employer.

A Leased Employee shall not be considered an Employee of the Employer if both of the following apply:

(a) Such employee is covered by a money purchase pension plan maintained by the leasing organization and which provides:

(i) A non-integrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), including amounts contributed pursuant to a salary reduction agreement under Code Section 125, 401(k), 402(h) or 403(b);

(ii) Immediate participation; and

(iii) Full and immediate vesting.

(b) Leased Employees do not constitute more than twenty percent (20%) of the Employer's non-highly compensated workforce.

1.37 Next Gen Employee Any Employee who participates in the "Next Gen" benefit structure offered by the Employer or a Related Employer and accordingly does not participate in the Plan (*i.e.*, does not accrue new or additional benefits under the Plan, other than Interest Credits, if applicable) or other defined benefit pension plan of a Related Employer. Such Next Gen Employee shall include (1) any Exempt Employee who is hired or rehired on or after January 1, 2010, (2) any non-union Non-Exempt Employee who is hired or rehired on or after January 1, 2013, and (3) any Union Employee who is hired or rehired on or after January 1, 2013. In addition, in accordance with Section 3.04(e), Next Gen Employee also shall refer to any Exempt or Non-Exempt Employee who transfers job positions (within the Employer or with a Related Employer) and who becomes or remains a Next Gen Employee after the transfer.

1.38 NiSource. NiSource Inc., a Delaware corporation, or any successor to it in the ownership of substantially all its assets. NiSource is the parent company of the Company.

1.39 Non-Exempt Employee. An Eligible Employee who is classified as a non-exempt employee under the payroll practices of an Employer.

1.40 Normal Retirement Age. The later of:

(a) the Participant's full Social Security Retirement Age; or

(b) the fifth anniversary of the date on which the Participant commenced participation in the Plan.

Notwithstanding the foregoing, in the case of a Participant who first became a Participant prior to January 1, 1989, solely for purposes of calculating such Participant's minimum benefit amount earned prior to January 1, 1989, Normal Retirement Age means the Participant's sixty-fifth birthday.

1.41 Normal Retirement Date. The first day of the month next following the Participant's Normal Retirement Age.

1.42 Opening Balance. The initial bookkeeping account established for a Participant's AB II Account or for a Participant's AB I Account, as provided in Section 4.03 or Section 5.03, respectively.

1.43 Participant. An Eligible Employee who has become a Participant under Article III. With respect to any action that may be taken by a Participant under the Plan, Participant shall include any person or entity appointed to represent a Participant under a validly executed Power of Attorney.

A Participant generally shall be exclusively at any given time an AB II Participant, AB I Participant or FAP Participant. Notwithstanding the foregoing, in the case of a FAP Participant who elects to become an AB II Participant or AB I Participant pursuant to an election period window, the Participant shall be treated as both a FAP Participant and an AB I Participant during the election period provided.

1.44 Pay-Based Credits. Additions to a Participant's Account determined pursuant to Sections 4.04 and 5.04 of the Plan.

1.45 Plan. The plan designated the Columbia Energy Group Pension Plan (f/k/a the Retirement Plan of Columbia Energy Group Companies) and sponsored by the Company, as set forth herein or in any amendments hereto.

1.46 Plan 2006 Restatement. The Plan document as amended and restated effective January 1, 2006.

1.47 Plan Administrator. The Committee, or such delegate of the Committee designated to carry out the administrative functions of the Plan.

1.48 Plan Sponsor. The Company is designated the sponsor of the Plan.

1.49 Plan Year. The calendar year.

1.50 Point Service. A period of employment used to determine the amount of Pay-Based Credits that are credited to a Participant's AB II Account or AB I Account, as defined in Section 2.03.

1.51 Protected Benefit. The benefit described under Section 4.06 and Section 5.06, as applicable.

1.52 Related Employer. The Company and any other entity which is related to the Company as a member of a controlled group of corporations in accordance with Code Section 414(b), or as a trade or business under common control in accordance with Code Section 414(c), or any organization which is part of an affiliated service group in accordance with Code Section 414(m), or any entity required to be aggregated with the Company in accordance with Code Section 414(o) and the regulations thereunder. If the Employer is a member of a group of Related Employers, the term "Employer" includes the Related Employers for purposes of determining Hours of Service and Years of Eligibility Service, Vesting Service and Credited Service, applying the participation test of Code Section 401(a)(26) and the coverage test of Code Section 410(b), applying the limitations of Article XIII, applying the Top Heavy rules and the minimum benefit requirements of Article XIX, the definitions of Employee, Highly Compensated Employee, Compensation and Leased Employee contained in this Article I, and for any other purpose as required by the Code or by the Plan. However, only a Related Employer which has adopted the Plan may participate therein, and unless specifically provided otherwise, only service during a period of employment while so participating shall count as Credited

Service or Point Service hereunder. For the purposes under the Plan of determining whether or not a person is an Employee and the period of employment of such person, each such other company shall be included as a Related Employer only for such period or periods during which such other company is a member of a controlled group, under common control, an affiliated service group or otherwise required to be aggregated with the Employer.

1.53 Severance from Service. An absence from employment, as defined in Section 2.05.

1.54 Single Life Annuity. An annuity providing monthly payments for the lifetime of the Participant with no survivor benefits.

1.55 Social Security Retirement Age. The age used as the full retirement age for the Participant under Section 216(l) of the Social Security Act as if the early retirement age under Section 216(l)(2) of such Act was age 62.

1.56 Spouse. The spouse of the Participant as recognized under the laws of the State in which the Participant resides. Notwithstanding the foregoing, effective September 16, 2013, the term "Spouse" shall include any individual who is lawfully married to a Participant under any State law, including individuals married to Participants of the same sex who were legally married in a State that recognizes such marriages, but who are domiciled in a State that does not recognize such marriages. For purposes of the foregoing sentence, "State" shall mean any domestic or foreign jurisdiction having legal authority to sanction marriages (*i.e.*, any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, any other territory or possession of the United States, and any foreign jurisdiction having the authority to sanction marriages).

1.57 Taxable Wage Base. The taxable wage base for old-age, survivors, and disability insurance as determined under Section 230 of the Social Security Act.

1.58 Termination of Service. The last date on which an individual performs duties as an Employee of the Company or Related Employer, or any other date determined in accordance with the Company's policies and practices.

1.59 Treasury Regulations. Regulations promulgated under the Internal Revenue Code by the Secretary of the Treasury.

1.60 Trust. The trust fund maintained in accordance with Article XVII from which benefits provided under the Plan will be paid.

1.61 Trust Agreement. The agreement establishing and maintaining the Trust, as provided for in Article XVII, as the same may be amended from time to time.

1.62 Trustee. The individual(s) and/or entity or entities appointed to administer and maintain the Trust in accordance with Article XVII.

1.63 Union Employee. An Employee covered by a collective bargaining agreement with the Employer.

1.64 Vested/Nonforfeitable. A Participant's or Beneficiary's unconditional claim, legally enforceable against the Plan, to all or a portion of the Participant's Accrued Benefit.

1.65 Vesting Service. A period of employment used to determine a Participant's eligibility to receive benefits, as defined in Section 2.01.

1.66 Terms Defined Elsewhere:

Annual Benefit ..... Section 13.06
Compensation (Top Heavy) ..... Section 19.03
Compensation (Section 415) ..... Section 13.06
Deferred Vested Benefit ..... Section 8.01
Defined Benefit Compensation Limitation ..... Section 13.06
Defined Benefit Dollar Limitation ..... Section 13.06
Determination Date (Top Heavy) ..... Section 19.03
Direct Rollover ..... Section 10.10
Distributee ..... Section 10.10
Early Retirement Benefit ..... Section 7.03
Elective Transfer ..... Section 21.04
Eligible Retirement Plan ..... Section 10.10
Eligible Rollover Distribution ..... Section 10.10
Employer (Top Heavy) ..... Section 19.03
Employer (Section 415) ..... Section 13.06
Investment Managers ..... Section 16.04
Key Employee ..... Section 19.03
Limitation Year ..... Section 13.06
Maximum Permissible Benefit ..... Section 13.06
Non-Key Employee ..... Section 19.03
Nontransferable Annuity ..... Section 10.08
Normal Retirement Benefit ..... Section 7.01
Permissive Aggregation Group ..... Section 19.03
Preretirement Survivor Annuity ..... Section 9.02
QDRO ..... Section 10.09
Qualified Joint and Survivor Annuity (QJSA) ..... Section 10.01
Required Aggregation Group ..... Section 19.03
Retroactive Annuity Starting Date ..... Section 10.12
Top Heavy ..... Section 19.02
Vested Retirement Date ..... Section 8.01
Year of Service (Section 415) ..... Section 13.06

ARTICLE II

SERVICE PROVISIONS

2.01 Vesting Service. "Vesting Service" means the period of employment with the Company or a Related Employer used to determine a Participant's eligibility to receive benefits. Vesting Service is also used to determine if an Employee's Vesting Service, Credited Service, and Point Service prior to a Break in Service shall be reinstated if the Employee is reemployed.

(a) In General. Except as otherwise provided in this Section and subject to Section 2.04, an Employee shall receive credit for Vesting Service for the period beginning on the first day on which the Employee performs an Hour of Service and ending on the Employee's Severance from Service. Vesting Service shall be determined in completed years and days, with each 365 days constituting one year.

(b) Disability. An Employee shall continue to earn Vesting Service while on Disability (regardless of whether the absence from employment due to the Disability lasts beyond one year and thus could constitute a "Severance from Service").

(c) Leased Employees. If a Leased Employee becomes eligible to participate in the Plan as a result of later employment with an Employer, the Leased Employee shall receive credit for Vesting Service as a Leased Employee.

2.02 Credited Service. "Credited Service" means the period of employment used to determine the amount of a Participant's FAP Benefit. Credited Service is also used to determine whether a Participant is entitled to commence distribution of his FAP Benefit before his Normal Retirement Date.

(a) In General. Except as otherwise provided in this Section and subject to Section 2.04, a Participant shall receive credit for Credited Service for the period beginning on the first day of the month that includes the first day on which the Participant performs an Hour of Service and ending on the Participant's Severance from Service. Credited Service shall be determined in completed years and months, with a month of Credited Service being credited for any month in which the Participant has at least one Hour of Service.

(b) Excluded Periods. Notwithstanding subsection (a), a Participant's Credited Service shall not include the following periods:

(i) in the case of any Participant who first performs an Hour of Service prior to January 1, 2000 and who terminates employment prior to May 1, 2007, the period prior to the first day of the month following the date on which the Participant attains age 21, but in no case later than January 1, 2000;

(ii) the period following the Participant's Conversion Date (if any), provided that this provision shall not apply in the case of a Participant who again becomes a FAP Participant following a Conversion Date; or

(iii) any period during which the Participant is in a position of employment either–

(A) as an Employee of an Employer where he does not meet the requirements to be a Participant; or

(B) as an Employee of a Related Employer that is not an Employer, except as otherwise provided in the Plan, such as in the Plan transfer provisions of Section 3.04.

(c) Disability. In the case of a Participant who has a Disability commencing on or after January 1, 2000, the Participant shall continue to earn Credited Service while the Disability continues (regardless of whether the absence from employment due to the Disability lasts beyond one year and thus could constitute a "Severance from Service"). In the case of a Participant who has a Disability commencing prior to January 1, 2000, the Participant shall earn Credited Service for:

(i) the period beginning on January 1, 2000 and continuing while the Participant's Disability lasts; plus

(ii) the period prior to January 1, 2000 during which the Participant both had a Disability and was eligible for disability benefits under the Social Security Act.

Credited Service shall cease to be credited pursuant to this subsection as of the earliest of (1) the date on which the Participant's Disability ends (which shall be deemed the Participant's Termination of Service unless returning to employment with the Company or Related Employer or unless the Employer determines a different Termination of Service date); (2) the date on which the Participant returns to employment with the Company or a Related Employer; or (3) the Participant's Benefit Commencement Date.

2.03 Point Service. "Point Service" means the period used to determine the amount of Pay-Based Credits that are credited to a Participant's AB I Account or AB II Account.

(a) In General. Except as otherwise provided in this Section and subject to Section 2.04, a Participant shall receive credit for Point Service for the period beginning on the first day of the month that includes the first day on which the Participant performs an Hour of Service and ending on the last day of the year in which the Participant's Termination of Service occurs. Notwithstanding the preceding sentence, if a Participant has a Severance from Service prior to January 1, 2000, the period of Point Service credited for this period of employment shall end on the Severance from Service. Notwithstanding the preceding sentences, Point Service for the year in which the Participant first performs an Hour of Service shall be determined in completed months, with a month of Point Service being credited for any month in which the Participant has at least one Hour of Service.

(b) Excluded Periods. Notwithstanding subsection (a), a Participant's Point Service shall not include the following periods:

(i) in the case of any Participant who first performs an Hour of Service prior to January 1, 2000 and who terminates employment prior to May 1, 2007, the period prior to the first day of the month following the date on which the Participant attains age 21, but in no case later than January 1, 2000; or

(ii) any period during which the Participant is in a position of employment –

(A) as an Employee of an Employer where he does not meet the requirements to be a Participant; or

(B) as a Union Employee, if the applicable collective bargaining agreement provides for benefit accruals to be determined under the FAP Benefit provisions, except as otherwise provided in the transfer provisions set forth in Section 3.04.

(c) Disability. In the case of a Participant who has a Disability commencing on or after January 1, 2000, the Participant shall continue to earn Point Service while the Disability continues (regardless of whether the absence from employment due to the Disability lasts beyond one year and thus could constitute a "Severance from Service"). In the case of a Participant who has a Disability commencing prior to January 1, 2000, the Participant shall earn Point Service for:

(i) the period beginning on January 1, 2000 and continuing while the Participant's Disability lasts; plus

(ii) the period prior to January 1, 2000 during which the Participant both had a Disability and was eligible for disability benefits under the Social Security Act.

Point Service shall cease to be credited pursuant to this subsection as of the earliest of (1) the date on which the Participant's Disability ends (which shall be deemed the Participant's Termination of Service unless returning to employment with the Company or Related Employer or unless the Employer determines a different Termination of Service date); (2) the date on which the Participant returns to employment with the Company or a Related Employer; or (3) the Participant's Benefit Commencement Date.

(d) Service with Related Employers. Point Service shall include any period during which an Employee is employed by an Employer or a Related Employer.

(e) Benefit Conversion. Notwithstanding subsection (a), in the case of a FAP Participant who elected to become an AB II Participant or AB I Participant pursuant to an election described in Schedule II, Point Service prior to the Participant's conversion to the AB II Benefit or AB I Benefit shall be equal to the amount of Credited Service (as determined under Section 2.02) the Participant earned prior to the Conversion Date.

2.04 Special Service Rules.

(a) Rehired Employees.

(i) In General. Subject to subsection (ii) below, an Employee who is rehired after having a Severance from Service shall have his Vesting Service, Credited Service, and Point Service reinstated upon reemployment as follows:

(A) If the Employee is reemployed before a Break in Service occurs, the Employee's complete and partial years of such service shall be reinstated upon reemployment. In addition, if the Employee is reemployed within one year after a Severance from Service that results from quit, discharge, or retirement, the Employee shall receive credit for such service for the period between the Employee's Severance from Service and reemployment.

(B) If the Employee is reemployed after a Break in Service occurs, the Employee shall not receive credit for service for the period between the Employee's Severance from Service and the Employee's reemployment. The Employee's complete and partial years of service earned prior to the Break in Service shall be reinstated only if–

1. the Employee was vested in any part of his benefits under the Plan prior to the Severance from Service; or

2. the number of consecutive Break in Service periods does not equal or exceed the greater of five years or the number of years of Vesting Service completed prior to the Break in Service. For purposes of this subparagraph, the number of years of Vesting Service completed prior to a Break in Service shall not include years of Vesting Service disregarded by reason of any prior Break in Service.

Notwithstanding the foregoing, an Employee's Credited Service and Point Service shall not be reinstated upon reemployment if the Employee has received a lump sum distribution of his retirement benefit after the earlier Termination of Service, except as otherwise provided in Section 11.02(b)(iii).

(ii) Next Gen Employees. With respect to any Employee who is rehired as a Next Gen Employee, the service reinstatement provisions set forth in subsection (i) shall not apply other than for Vesting Service. Such rehired Next Gen Employee shall not receive reinstatement of or additional credit of Credited Service or Point Service.

(b) Prior Service. If a Participant's period of employment prior to January 1, 1976 is not continuous up through and including that date, it shall be treated as Vesting Service, Credited Service, and Point Service only to the extent it is credited as Credited Service under the terms of the Plan as in effect prior to January 1, 1976.

(c) Authorized Leaves and Other Absences. Subject to subsections (e) and (f) below, an Employee's Vesting Service, Credited Service, and Point Service shall include any period of an Authorized Leave of Absence up to 12 months. Vesting Service, Credited Service, and Point Service shall also include periods of absences for such other reasons and within such time limitations as may be approved by the Committee for general application to all Employees.

(d) Acquired Businesses. If an individual becomes an Employee upon the acquisition of all or a portion of the business of his former employer by the Company or a Related Employer, whether by merger, acquisition of assets or stock, or otherwise, his service with the predecessor employer shall be included in determining his Vesting Service, Credited Service, and Point Service if, and to the extent that, this service is required to be credited by–

(i) Code Section 414(a);

(ii) the terms of the agreement under which the Company or Related Employer acquired the business of the former employer; or

(iii) a specific approval by the Committee.

Notwithstanding the foregoing, any such agreement or Committee action may provide that the prior period of employment shall be taken into account only when determining the Employee's Vesting Service, Credited Service, or Point Service, or any combination of these types of service.

(e) Military Service. Notwithstanding any provision of the Plan to the contrary, effective December 12, 1994, contributions, benefits and service credits with respect to qualified military service shall be provided in accordance with Code Section 414(u).

(f) Family and Medical Leave. Notwithstanding any provision of the Plan to the contrary, any Participant on leave under the Family and Medical Leave Act of 1993 shall receive contributions, benefits and service credits in accordance with such Act.

(g) Crediting for Specific Groups.

(i) Triana Energy Holdings, Inc. Any continuous period of employment with Triana Energy Holdings, Inc. ("Triana") beginning on or after September 1, 2003 shall be included for purposes of determining Vesting Service for any Participant who became an employee of Triana as a result of Triana's acquisition of all of the issued and outstanding shares of stock of Columbia Energy Resources pursuant to the Stock Purchase Agreement dated July 3, 2003 among the Company, Triana and NiSource Inc.; provided, however, in no event shall any such period of employment be taken into account for any purpose other than determining a Participant's vested interest in his Accrued Benefit determined as of September 1, 2003.

(ii) IBM. While the Vesting Service provisions set forth in this Article II continue to apply, with respect to any Participant who (1) was notified in writing on June 21, 2005 or any following date up to and including December 31, 2005, that his employment was outsourced to the International Business Machines Corporation ("IBM"), or (2) received an initial Severance Letter Agreement dated June 21, 2005, or any following date up to and including December 31, 2005, from NiSource in connection with NiSource's outsourcing agreement with IBM, then such Participant shall be subject to a 3-year cliff Vesting provision as set forth in Section 8.02, effective as of such outsourcing date(s).

(iii) Terminations Between January 1, 1999 and December 31, 2001. In connection with the partial termination of the Plan, and consistent with Section 21.06 of the Plan, Participants terminating employment between January 1, 1999 and December 31, 2001 shall be 100% Vested in their Accrued Benefit, regardless of the number of years of Vesting Service such Participants completed as of Severance from Service. Such Participants shall not be subject to the vesting provisions of Section 8.02.

2.05 Severance from Service. "Severance from Service" means the earlier of subsection (a) or (b) below:

(a) the date the Employee quits, retires, is discharged, or dies; or

(b) the first anniversary of the first day of an Employee's absence from employment with the Company or a Related Employer (with or without pay) for any reason other than in (a) above, such as vacation, sickness, leave of absence, layoff, or military service (except as otherwise provided for Disabled Employees and in Section 2.04). Notwithstanding the foregoing, in no event shall an Employee have a Severance from Service solely as a result of taking an authorized leave of absence pursuant to the Family and Medical Leave Act of 1993.

An Employee who fails to return to employment at the expiration of an absence shall be deemed to have had a Severance from Service on the earlier of the expiration of the Employee's absence or the first anniversary of the first day of the Employee's absence.

2.06 Break in Service. "Break in Service" means each 12 consecutive month period beginning on the date an Employee incurs a Severance from Service and ending on the anniversary of that date, provided that the Employee does not perform an Hour of Service during that period.

Solely for purposes of determining whether a Break in Service has occurred, if an Employee is absent from work beyond the first anniversary of the first date of an absence and the absence is for maternity or paternity reasons, the date the Employee incurs a Break in Service shall be the second anniversary of the Employee's absence from employment. The period between the first and second anniversary of the first date of absence shall not constitute service. For purposes of this section, an absence from work for maternity or paternity reasons means an absence by reason of (1) the Employee's pregnancy, (2) the birth of the Employee's child, (3) the placement of a child with the Employee in connection with the adoption of the child, or (4) the caring for a child for a period immediately following the child's birth or placement.

ARTICLE III

PARTICIPATION AND TRANSFERS

3.01 Date of Participation. An Eligible Employee shall participate in the Plan as follows:

(a) An Eligible Employee who was a Participant in the Plan on the day before the Effective Date of this restated Plan shall continue as a Participant in this Plan as restated.

(b) Any other Eligible Employee shall become a Participant on the date on which he first performs an Hour of Service as an Eligible Employee.

(c) The Plan Administrator shall determine the eligibility of each Employee to participate in the Plan for each Plan Year based on information furnished by the Employer. Such determination shall be within the discretion of the Plan Administrator and shall be conclusive and binding upon all persons as long as such determination is made pursuant to the Plan and ERISA.

In accordance with the definition of "Eligible Employee" set forth in the Plan, Next Gen Employees are not eligible to participate in (*i.e.*, cannot accrue new or additional benefits under) the Plan.

3.02 Participation Upon Reemployment. If a former Eligible Employee again becomes an Employee after a Severance from Service, such Employee shall be considered a Next Gen Employee and no longer eligible to actively participate in the Plan (*i.e.*, cannot accrue new or additional benefits under the Plan, other than Interest Credits, if applicable).

3.03 Continuation of Participation. A Participant shall continue to be a Participant as long as he has an undistributed beneficial interest in the Plan. In accordance with Article VIII, if upon Termination of Service a Participant's Vested Accrued Benefit is zero, the Participant shall be deemed to have received an immediate lump sum payment of his benefit and shall thereupon cease to be a Participant.

3.04 Transfers. Unless otherwise indicated, the provisions of this Section 3.04 shall be effective for transfers occurring on or after January 1, 2013. Transfers occurring prior to such date shall be governed by the provisions as set forth in the Plan 2011 Restatement.

(a) Transfers from Related Employers. Notwithstanding any provision to the contrary contained in the Plan, and subject to the exception set forth in subsection (e) below, the provisions of this subsection (a) shall govern the benefit accrual of any Employee who transfers to employment otherwise providing coverage under the Plan and who was covered under a Related Employer's defined benefit plan on the date of transfer. The treatment of such Employee's benefit accrual shall depend on the nature of the position (*i.e.*, Exempt or Non-Exempt, union or non-union) from and to which the Employee transfers, and in instances set forth in subsection (e), the date of hire of such Employee, as set forth below.

(i) If transferring from a non-union position (either as an exempt or non-exempt employee) covered under the Related Employer's plan to employment as a non-union Employee (either an Exempt or a Non-Exempt Employee), then such Employee shall continue to accrue a benefit under such Related Employer's plan and shall accrue no benefit under the Plan from and after the date of transfer. In accordance with the terms of the Related Employer's plan, the transferred Employee shall remain subject to the benefit accrual method in effect for the Employee prior to the transfer.

(ii) If transferring (a) from a non-union position covered under the Related Employer's plan to employment as a Union Employee, or (b) from a union position covered under the Related Employer's plan to employment as an Exempt Employee or as a Non-Exempt Employee (non-union or union), then such Employee shall cease to accrue a benefit in such Related Employer's plan as of the date of transfer and shall begin to participate as a new AB II Benefit Employee in the Plan on the date of such transfer. Such Employee shall receive a $0 Opening Balance and shall have Vesting Service and Point Service under the Plan calculated to include service earned under the Related Employer's plan prior to the transfer. For purposes of the benefit accrued under the Related Employer's plan (e.g., for calculating the frozen benefit earned under such plan), "Credited Service" under such plan shall cease as of the date of transfer, except that the Participant's service with the Employer or any Related Employer shall also be counted as "Credited Service" under the plan with the frozen benefit solely for purposes of determining eligibility for the "Early Retirement Benefit" under such plan (but for no other purpose).

(b) Transfers to Related Employers. Notwithstanding any provision to the contrary contained in the Plan, and subject to the exception set forth in subsection (e) below, the provisions of this subsection (b) shall govern the benefit accrual of any Employee who transfers from employment that provides for coverage under the Plan to employment of a Related Employer that has not adopted the Plan as of the date of transfer. The treatment of such Employee's benefit accrual shall depend on the nature of the position (*i.e.*, Exempt or Non-Exempt, union or non-union) from and to which the Employee transfers as set forth below.

(i) If transferring from a non-union position (either as an Exempt Employee or a Non-Exempt Employee) covered under the Plan to a non-union position of a Related Employer that has not adopted the Plan, then such Employee shall continue to accrue a benefit under the Plan and shall accrue no benefit under the Related Employer's defined benefit plan (if any) from and after the date of transfer. Such Employee shall continue to be considered an Employee in the Plan, and shall continue to earn Point Service under the Plan from and after the date of transfer until the date of his Termination of Service.

(ii) If transferring (a) from a union position covered under the Plan to a non-union position (either exempt or non-exempt) of a Related Employer that has not adopted the Plan, or (b) from any position covered under the Plan (an Exempt Employee or a Non-Exempt Employee, union or non-union) to employment in a union position of a Related Employer that has not adopted the Plan, the Accrued Benefit of the Employee in the Plan shall be frozen as of the date of his transfer and such Employee shall begin to participate in the Related Employer's defined benefit plan (if any) as a new "AB II Benefit" employee, if applicable, on the date of such transfer. If the AB II Benefit structure is not offered in the Related Employer's plan, such plan's "AB I" benefit structure or final average pay benefit structure, as applicable, shall apply. If either the AB II or AB I benefit structure applies, all service both before and after the date of transfer shall be included in the Employee's point service under such Related Employer's plan. If the final average pay benefit structure applies, only service after the date of transfer shall be included for purposes of benefit accrual under the Related Employer's plan. For purposes of the Employee's frozen benefit under the Plan, such Employee shall cease to earn Pay-Based Credits as of the date of such transfer, unless he again transfers to employment providing coverage under the Plan, but shall continue to earn Interest Credits until the date his pension commences.

(iii) Notwithstanding subsection (ii) above, if transferring from a union position covered under the Plan to a non-union position with NiSource Corporate Services, then such Employee shall continue to accrue a benefit under the Plan.

(c) Transfers within the Plan. Notwithstanding any provision to the contrary contained in the Plan, and subject to the exception set forth in subsection (e) below, any Employee who transfers between employment positions that are both covered under the Plan (*e.g.*, Non-Exempt Employee to Exempt Employee (or vice versa), union to non-union (or vice versa) or Exempt or Non-Exempt positions with different divisions covered under the Plan) shall continue to participate in the Plan as an AB II Benefit Participant after such transfer.

(d) Transfer from Disabled to Active Status. For any Participant who returns to active work immediately after a Disability, such Participant shall continue to have his accruals after returning to active work status determined under the AB II Benefit provisions of Article IV of the Plan. Notwithstanding the foregoing, similar to the exception described in subsection (e) below, if a Disabled Participant returns to active work on or after January 1, 2013, such Participant shall continue to accrue benefits under the Plan (which shall be under the AB II Benefit Provisions) provided that the Participant, prior to the occurrence of the Disability, was hired or rehired prior to the date that the Next Gen Employee benefit paradigm was implemented (*i.e.*, hired/rehired prior to January 1, 2010 if returning to active employment as an Exempt Employee; or hired/rehired prior to January 1, 2013 if returning to active employment as a Non-Exempt Employee; or not otherwise originally hired/rehired as a Next Gen Employee).

Prior to January 1, 2009, a Participant who returned to active work after a Disability was entitled to make a cash balance election in accordance with the provisions of Schedule II (4).

(e) Next Gen Employee Transfers. In accordance with the definition of "Eligible Employee" and the participation provisions of Section 3.01, Employees who are classified as Next Gen Employees are not eligible to accrue new or additional benefits under the Plan. The transfer provisions set forth in this Section 3.04 shall be modified for Next Gen Employees as follows:

(i) Transfer of Employee Hired/Rehired Prior to January 1, 2010. The transfer provisions of this Section 3.04 shall continue to apply to any Employee who was hired or rehired prior to January 1, 2010. Such an Employee is not considered a Next Gen Employee (unless he/she terminates employment and is rehired as a Next Gen Employee).

(ii) Transfer of Employee Hired/Rehired On or Between January 1, 2010 and December 31, 2012. With respect to an Employee who was hired or rehired on or between January 1, 2010 and December 31, 2012, the treatment of such Employee's benefit accrual (or status as a Next Gen Employee) upon a transfer shall depend on the nature of the position (*i.e.*, Exempt or Non-Exempt, union or non-union) from and to which the Employee transfers as set forth below.

(A) Transfer From Exempt or Non-Exempt to Exempt Employee Status. Any Exempt Employee who is hired or rehired on or after January 1, 2010 is a Next Gen Employee and not eligible to accrue benefits under the Plan. Similarly, any Employee hired/rehired on or between January 1, 2010 and December 31, 2012 (whether Exempt or Non-Exempt) who transfers to an "Exempt Employee" position with the Employer (or a Related Employer) shall remain or become a Next Gen Employee on the date of such transfer and shall accrue no additional benefit under the Plan (or the plan of a Related Employer, in the case of transfers to a Related Employer).

(B) Transfer From Exempt to Non-Exempt Employee Status. Similar to subsection (ii)(A) above, any Next Gen Employee who transfers from an "Exempt Employee" position with the Employer (or a Related Employer) to a Non-Exempt position with the Employer (or a Related Employer) shall remain a Next Gen Employee and shall not participate in the Plan (or the plan of a Related Employer). However, if such Next Gen Employee transfers to a union position that does not offer the Next Gen benefit structure, then such employee will participate in the benefit structure offered pursuant to the applicable collective bargaining agreement.

(C) Transfer from Non-Exempt to Non-Exempt Employee Status. Subject to the exception set forth in this subsection (C) for certain union employees of Related Employers, any Non-Exempt Employee hired/rehired on or between January 1, 2010 and December 31, 2012 who transfers to a different Non-Exempt Employee position is not considered a Next Gen Employee (unless he/she terminates employment and is rehired on or after January 1, 2013). Accordingly, the transfer provisions of this Section 3.04 generally shall continue to apply. Notwithstanding the foregoing, with respect to any union employee of a Related Employer who is considered a "Next Gen Employee" by such Related Employer (due to being hired or rehired on or after implementation of Next Gen provisions effective January 1, 2011), such employee shall remain a Next Gen Employee upon transfer and shall not participate in the Plan.

(iii) Transfer of Employee Hired/Rehired On or After January 1, 2013. Subject to the exception set forth in the next sentence, any Next Gen Employee (who is classified as such because hired or rehired on or after January 1, 2013) shall remain a Next Gen Employee upon the transfer to or from the Employer (or a Related Employer) and shall not participate in the Plan (or the plan of a Related Employer). Notwithstanding the foregoing, if such Next Gen Employee transfers to a union position that does not offer the Next Gen benefit structure, then such employee will participate in the benefit structure offered pursuant to the applicable collective bargaining agreement.

(f) Impact of Plan Conversion for Any Frozen Prior Benefit. Notwithstanding any other provision in this Section 3.04, any Employee who transfers positions to become an AB II Participant (in accordance with the transfer provisions of the Plan) shall be subject to Section 4.07 of this Plan and the analogous section of an applicable other defined benefit plan of the Employer or Related Employer.

3.05 Conditions of Participation.

Participation in this Plan by any Eligible Employee shall be contingent upon receipt by the Plan Administrator of such applications, consents, proofs of birth, elections, beneficiary designations and other documents and information as prescribed by the Plan Administrator. Each Employee, upon becoming a Participant, shall be deemed conclusively and for all purposes to have assented to the terms and provisions of this Plan and shall be bound thereby.

ARTICLE IV

AB II BENEFIT

4.01 Applicability of Article. This Article IV sets forth the method for determining the ongoing benefit accrual under the Plan on or after the Effective Date for any Participant who is an Eligible Employee on or after the Effective Date.

(a) Participants Entitled to AB II Benefit. The provisions of this Article shall apply in determining the Accrued Benefit for any Participant described as follows:

(i) any Non-Exempt Employee (whether or not a Union Employee) hired or rehired on or after January 1, 2008 but before January 1, 2013;

(ii) all Non-Exempt Employees who are participating in the Plan on and after January 1, 2013 (including all Non-Exempt Employees on Disability as of January 1, 2013) who transition to the AB II Benefit pursuant to Section 4.07;

(iii) all Exempt Employees who are participating in the Plan on and after January 1, 2011, including

(A) any Exempt Employee newly hired or rehired on or after October 1, 2005 but before January 1, 2010;

(B) any Exempt Employee who elected to participate in the AB II Benefit effective January 1, 2006 as described in Schedule II;

(C) any formerly Disabled Exempt Employee who elected to participate in the AB II Benefit upon return to active employment in accordance with Schedule II (4) or who became an AB II Participant automatically in accordance with Section 3.04;

(D) all Disabled Exempt Employees participating in the Plan on and after January 1, 2012; and

(iv) certain other persons who elected to participate in the AB II Benefit or were transitioned to the AB II Benefit pursuant to the provisions of Plan 2006 Restatement, Schedule II or the transfer provisions of Section 3.04.

This Article did not apply to any Non-Exempt Employee prior to January 1, 2008 (other than a formerly Exempt Employee who was an AB II Participant, transferred to a Non-Exempt Employee position, and remained an AB II Participant in accordance with the Plan's transfer provisions). In addition, this Article shall not apply to any Next Gen Employee.

(b) Election of AB II Benefit. Certain Participants shall be entitled (or were entitled) to elect to have their benefit accruals determined under this Article IV in accordance with the cash balance election provisions set forth in Schedule II of the Plan and as further described in the Plan 2006 Restatement.

4.02 AB II Benefit. Except as otherwise provided under this Article and subject to Article XIII, the AB II Benefit is the Participant's AB II Account, calculated in accordance with Section 4.03. Notwithstanding the foregoing, for benefit distributions occurring prior to January 1, 2008, the AB II Benefit was a monthly benefit equal to

the Participant's AB II Account, increased with interest at the annual rate for Interest Credits in effect as of the determination date to the Participant's Normal Retirement Date (if the Participant has not reached his Normal Retirement Date) and then converted to an Actuarial Equivalent Single Life Annuity commencing as of the Participant's Normal Retirement Date (or Late Retirement Date, if applicable).

For any AB II Participant, the AB II Benefit shall be used to determine the Participant's retirement benefit in accordance with the provisions of Articles VII and VIII and shall be subject to the Protected Benefit provisions of Section 4.06.

4.03 AB II Account.

(a) In General. On the date an Eligible Employee becomes an AB II Participant, an AB II Account shall be established for such AB II Participant. A Participant's AB II Account is a notional account equal to the sum of his—

(i) Opening Balance (if any), calculated pursuant to subsection (b) below;

(ii) Pay-Based Credits, calculated pursuant to Section 4.04; and

(iii) Interest Credits, calculated pursuant to Section 4.05.

An AB II Account shall be a bookkeeping account used to calculate the benefit of an AB II Participant under the Plan. The amounts credited to the AB II Account from time to time shall not represent any interest in any segregated assets of the Trust or otherwise create a right in any Participant, Beneficiary or other person to receive specific assets in the Trust. Benefits under the Plan shall be paid from the general assets of the Trust in the amounts and at the times provided under the terms of the Plan.

(b) Opening Balance. An Opening Balance shall be calculated for a Participant who becomes an AB II Participant in accordance with the provisions set forth below.

(i) FAP Benefit Conversions. In the case of a FAP Participant who becomes an AB II Participant, an Opening Balance shall be determined as follows:

(A) determine the Participant's Accrued Benefit under the Plan as of the Conversion Date;

(B) reduce the amount in subparagraph (A) by 0.25% for each month from the Participant's Calculation Date (as defined below) to the later of (a) the Conversion Date or (b) the first day of the month following the date on which the Participant would attain age 60. If the first day of the month coincident with or next following the date on which the Participant would reach his/her Calculation Date is on or before the date the Participant becomes an AB II Participant, then no reduction;

(C) calculate the lump sum Actuarial Equivalent of the amount in paragraph (B) using the Actuarial Equivalent factors set forth in Section 1.08 for lump sum present value calculations, or with respect to Opening Balance calculations for all Disabled Exempt Employees converting to the AB II Benefit on January 1, 2012, using an interest rate of 3.77%.

The result is equal to the Participant's Opening Balance. For purposes of the calculation set forth in this subsection, a Participant's "Calculation Date" is the date three years prior to the Participant's Normal Retirement Date. Notwithstanding the foregoing, in the case of a

Participant who first became a Participant prior to January 1, 1989, solely for purposes of ensuring that the Opening Balance is no less than such Participant's minimum benefit amount earned prior to January 1, 1989, the Calculation Date shall be modified as follows: (1) for Employees hired between January 1, 1976 and January 1, 1989, the Calculation Date is the first day of the month coinciding with or next following the Participant's 62nd birthday; or (2) for Employees hired prior to January 1, 1976, the Calculation Date is the first day of the month coinciding with or next following the Participant's 65th birthday.

(ii) AB I Benefit Conversions. In the case of any AB I Participant who becomes an AB II Participant, the Opening Balance shall be the balance of his AB I Account as of the Conversion Date, including any Pay-Based Credits and Interest Credits earned pro-rata for that Plan Year up until the Conversion Date.

(iii) Conversion After Reemployment. Effective January 1, 2008, in the case of a Participant who is receiving an annuity benefit as an AB II Participant, AB I Participant, or FAP Participant and who is reemployed, such benefits shall be suspended pursuant to Article XI. Subject to the exception for Next Gen Employees, as described in Section 11.02, an Opening Balance shall be determined as of the applicable Conversion Date, equal to the lump sum present value of all remaining payments due the Participant based on the prior benefit election made under Article X of the Plan as if such reemployment had not occurred. The lump sum present value of such remaining payments shall be determined using the Actuarial Equivalent factors set forth in Section 1.08.

4.04 Pay-Based Credits. Effective as of the date a Participant becomes an AB II Participant and up until the time that the Participant has a Termination of Service or otherwise stops accruing a benefit under the AB II Benefit provisions, a Pay-Based Credit shall accrue to his or her AB II Account as of the last day of each Plan Year. The amount of the Pay-Based Credit shall equal a percentage of the Participant's Compensation for the Plan Year, plus an additional percentage of the Participant's Compensation in excess of one-half of the Taxable Wage Base for the Plan Year. The determination of Pay-Based Credits shall be based on the sum of the Participant's age and Point Service in accordance with the following table:

Age Plus Point Service	Percentage of Compensation	Percentage of Compensation Above ½ Taxable Wage Base
Fewer than 50	4.0%	1.0%
50-69	5.0%	1.0%
70 and over	6.0%	1.0%

For purposes of this Section, a Participant's age plus Point Service is calculated as follows:

(i) A Participant's age means the time period from the first day of the month following the date of the Participant's birth to the January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated.

(ii) A Participant's Point Service as of January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated is added to the Participant's age, calculated as described in (i) above.

(iii) The sum calculated in (ii) above, as rounded down into a whole integer, applies for purposes of this Section 4.04 for such Plan Year.

For the Plan Year that an AB II Participant has a Termination of Service, such AB II Participant shall receive a Pay-Based Credit based on Compensation and Point Service earned through the date of the Termination of Service.

4.05 Interest Credits. Interest Credits shall be credited to a Participant's AB II Account for each Plan Year as of December 31, based on the balance of the AB II Account as of the last day of the prior Plan Year (after Pay-Based Credits and Interest Credits are credited for that prior Plan Year). The rate used for determining Interest Credits (the "Interest Credit Rate") shall be equal to the annual interest rate on 30-year Treasury Securities, as determined and published by the Internal Revenue Service pursuant to Notice 2002-26, 2002-15 I.R.B. 743, for the month of September immediately preceding the first day of the Plan Year, but not less than 4%. The additional following provisions apply:

(a) For Year Payment Commences. In the case of a Participant who receives or begins to receive a distribution of his AB II Benefit prior to December 31 of a Plan Year, Interest Credits for such Plan Year shall be credited on a prorated basis to his AB II Account for the period from the prior December 31 until the date when the distribution is paid or commences. The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an Employee and the denominator of which is 12.

(b) For Initial Year of Participation. In the case of a Participant who becomes an AB II Participant during a Plan Year, Interest Credits shall be credited on a prorated basis based on the Opening Balance determined pursuant to Section 4.03(b). The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an AB II Participant and the denominator of which is 12.

(c) Interest Crediting After Termination. In the case of a Participant who has a Termination of Service and who is not vested in his AB II Account, Interest Credits shall not be credited to such Participant's AB II Account after such Termination of Service and shall not be credited for the period of absence from employment in the event the Participant is subsequently reemployed. If the Participant is subsequently reemployed, the Plan shall begin to credit Interest Credits to the Participant's Account (whether vested or nonvested) effective as of the date of the Participant's reemployment (however, for any Next Gen Employee, no additional Pay-Based Credits shall accrue). In the case of a Participant who has a Termination of Service and who is vested in his AB II Account, Interest Credits shall continue to be credited to such Participant's AB II Account as provided above in this Section up until the date the Participant begins distribution of his benefit.

(d) Market Rate of Return Rules. The Interest Credit Rate described above is intended not to exceed a "market rate of return" as set forth in Code Section 411(b)(5)(B) and as further described in Proposed Treasury Regulation Section 1.411(b)(5)-1(d) and may be modified in a future amendment if required by finalized Treasury Regulations or other guidance. In addition, upon the termination of the Plan, the following shall apply: (1) the rate of interest used to determine accrued benefits under the Plan shall be equal to the average of rates of interest used under the Plan during the 5-year period ending on the termination date; and (2) the interest rate and mortality table used to determine the amount of any benefit under the Plan payable in the form of an annuity payable at Normal Retirement Age shall be the rate and table specified under the Plan for such purpose as of the termination date, except that if such interest rate is a variable rate, the interest rate shall be determined under the rules of subclause (1).

4.06 Protected Benefit for AB II Participant. In no event shall the Accrued Benefit due any Participant under the AB II Benefit provisions of the Plan be less than the amount protected under (a) or (b) below.

(a) Transition from FAP Benefit to AB II Benefit. If a Participant transitions from participation under the FAP Benefit to the AB II Benefit, such Participant's Accrued Benefit shall be no less than the sum of (i) his FAP Benefit determined under Article VI as of the applicable Conversion Date, and (ii) his AB II Benefit as of his Termination of Service (calculated without regard to his Opening Balance).

(b) Transition from AB I Benefit to AB II Benefit. For a Participant who transitions from the FAP Benefit to the AB I Benefit before transitioning from the AB I Benefit to the AB II Benefit, such Participant's Accrued Benefit shall be no less than his FAP Benefit when it was converted to the AB I Benefit (expressed as a Single Life Annuity payable at the Participant's Normal Retirement Date, which does not include any supplemental benefit). Further, for a Participant who transitions from the AB I Benefit to the AB II Benefit, such Participant's Accrued Benefit shall be no less than the sum of (i) his AB I Benefit determined under Article V as of the Conversion Date from the AB I to the AB II Benefit, and (ii) his AB II Benefit as of his Termination of Service (calculated without regard to his Opening Balance under the AB II Benefit provisions).

In addition to the preservation of the above-stated Protected Benefit, the Plan shall also preserve any other benefit, right or feature that is required by law to be preserved with respect to any Participant, including the use of any applicable actuarial equivalence or conversion factors or the availability of any additional forms of distribution.

4.07 Transition of All Participants to the AB II Benefit. Notwithstanding anything to the contrary, any Participant described under this Section 4.07 (who is not already an AB II Participant) shall accrue such benefit pursuant to the AB II Benefit provisions of this Article IV. Specifically, effective as of the dates indicated, the AB II Benefit provisions shall apply to: (1) any Exempt Employee who is accruing a benefit under the Plan on or after January 1, 2011; (2) any Disabled Exempt Employee who is accruing a benefit under the Plan on or after January 1, 2012; and (3) any Non-Exempt Employee who is accruing a benefit under the Plan on or after January 1, 2013 (including any Disabled Non-Exempt Employee).

In connection with the January 1, 2011 and January 1, 2013 conversions of benefits of Employees to the AB II Benefit, all previously accrued frozen FAP Benefits will be converted to an AB II Benefit for all active Exempt Employees and active Non-Exempt Employees (as well as Disabled Exempt or Non-Exempt Employees) who are accruing a benefit under this Plan (whether through continued employment, transfer, or rehire). Accordingly, with respect to any undistributed FAP Benefit earned during a prior period of employment (whether under this Plan or under another defined benefit plan of the Employer or a Related Employer), such frozen benefit will be converted to an Opening Balance in accordance with the provisions of the plan in which the frozen benefit was accrued. The conversion of a previously accrued frozen FAP Benefit will be effective as follows: (1) on January 1, 2011 for Participants (January 1, 2012, for applicable Disabled Participants) who are accruing an AB II Benefit as an active Exempt Employee on such date (or, if later, as of the date the Participant becomes an active Exempt Employee accruing an AB II Benefit under the Plan) or (2) on January 1, 2013 for Participants who are accruing an AB II Benefit as an active (or Disabled) Non-Exempt Employee on such date (or, if later, as of the date the Participant becomes an active Non-Exempt Employee accruing an AB II Benefit under the Plan). The Opening Balance (reflecting the converted frozen FAP Benefit) shall have the following conditions apply:

(i) The Opening Balance shall earn Interest Credits in accordance with the AB II Benefit provisions of the plan in which the frozen benefit was accrued (or if AB II Benefit provisions do not exist in such plan, then in accordance with the plan's AB I Benefit provisions).

(ii) If a Participant's converted frozen benefit was previously earned under a plan other than this Plan, such benefit shall remain in such plan and will be tracked separately from any benefit earned under this Plan.

(iii) If a Participant's converted frozen benefit was previously earned under this Plan, then for administrative simplicity, the Plan Administrator may, in its discretion, elect to track a Participant's previously accrued frozen benefit separately from the Participant's ongoing benefit under the Plan.

(iv) A Participant who has a benefit converted to an Opening Balance pursuant to this paragraph shall never receive less than the previously accrued frozen FAP Benefit earned prior to the conversion.

ARTICLE V

AB I BENEFIT

5.01 Applicability of Article. This Article V sets forth the benefit accrual provisions for any Participant who was an AB I Participant under the Plan at some point prior to the Effective Date. No additional benefit accruals under the Plan shall be governed by this Article V. This Article V also sets forth the provisions necessary to determine a Protected Benefit based on a prior AB I Benefit.

(a) Participants Entitled to AB I Benefit. The provisions of this Article shall apply in determining the Accrued Benefit for any Participant who is not an AB II Participant under Article IV and who was described as follows:

(i) any Participant who first became a Non-Exempt Employee on or after January 1, 2000 but before January 1, 2008;

(ii) any former Employee (other than a Union Employee) who became a Non-Exempt Employee on or after January 1, 2000 but before January 1, 2008 following a Termination of Service;

(iii) any Participant who elected to participate in the AB I Benefit pursuant to one of the election periods described in Schedule II of the Plan;

(iv) any Participant who became an Exempt Employee (newly hired or rehired) on or after January 1, 2000 but before October 1, 2005;

(v) any Participant who became an Exempt Employee (hired or rehired) on or after October 1, 2005 but before January 1, 2006; provided such Participant accrued benefits under the AB I Benefit provisions only until January 1, 2006 at which time such Participant participated under the AB II Benefit provisions; and

(vi) any former Non-Exempt Employee participating under this Article who transferred employment to become an Exempt Employee on or after October 1, 2005 but before January 1, 2009.

Notwithstanding the foregoing, this Article V shall not apply to (1) former Exempt Employees who were eligible to make an election to have their benefits determined under this Article V effective January 1, 2000, failed to make such election, and subsequently became Non-Exempt Employees, (2) any Non-Exempt Employee (including any Union Non-Exempt Employee) first hired on or after January 1, 2008; (3) any Exempt or Non-Exempt Employee (including any Union Exempt or Non-Exempt Employee) rehired or returning to employment on or after January 1, 2008; (4) any Exempt Employee accruing a benefit under the Plan on or after January 1, 2011; (5) any Disabled Exempt Employee accruing a benefit under the Plan on or after January 1, 2012; and (6) any Non-Exempt Employee (including any Disabled Non-Exempt Employee) accruing a benefit under the Plan on or after January 1, 2013.

(b) Election of AB I Benefit. Certain Participants were entitled to elect to have their benefit accruals determined under this Article V in accordance with the cash balance election provisions set forth in Schedule II of the Plan and as further described in the Plan 2006 Restatement.

5.02 AB I Benefit. Except as otherwise provided under this Article, the AB I Benefit is the Participant's AB I Account, calculated in accordance with Section 5.03. Notwithstanding the foregoing, for benefit distributions occurring prior to January 1, 2008, the AB I Benefit was a monthly benefit equal to the Participant's AB I Account, increased with interest at the annual rate for Interest Credits in effect as of the determination date to the Participant's Normal Retirement Date (if the Participant has not reached his Normal Retirement Date) and then converted to an Actuarial Equivalent Single Life Annuity commencing as of the Participant's Normal Retirement Date (or Late Retirement Date, if applicable).

For any AB I Participant, the AB I Benefit shall be used to determine the Participant's retirement benefit in accordance with the provisions of Articles VII and VIII and shall be subject to the Protected Benefit provisions of Section 5.06.

5.03 AB I Account.

(a) In General. On the date an Eligible Employee becomes an AB I Participant, an AB I Account shall be established for such AB I Participant. A Participant's AB I Account is a notional account equal to the sum of his—

(i) Opening Balance (if any), calculated pursuant to subsection (b) below;

(ii) Pay-Based Credits, calculated pursuant to Section 5.04; and

(iii) Interest Credits, calculated pursuant to Section 5.05.

An AB I Account shall be a bookkeeping account used to calculate the benefit of an AB I Participant under the Plan. The amounts credited to the AB I Account from time to time shall not represent any interest in any segregated assets of the Trust or otherwise create a right in any Participant, Beneficiary or other person to receive specific assets in the Trust. Benefits under the Plan shall be paid from the general assets of the Trust in the amounts and at the times provided under the terms of the Plan.

(b) Opening Balance. An Opening Balance shall be calculated for a Participant who becomes an AB I Participant in accordance with the provisions set forth below.

In the case of a FAP Participant who becomes an AB I Participant, an Opening Balance shall be determined as follows:

(A) determine the Participant's Accrued Benefit under the Plan as of the Conversion Date;

(B) subtract from the FAP Benefit the amount of any annuity purchased on the Participant's behalf (if applicable) pursuant to Section 10.08, which annuity shall be expressed as a Single Life Annuity commencing at the Participant's Normal Retirement Date (or Delayed Retirement Date, if applicable);

(C) reduce the amount in subparagraph (A) by 0.25% for each month from the Participant's Calculation Date (as defined below) to the later of (a) the Conversion Date or (b) the first day of the month following the date on which the Participant would attain age 60;

(D) calculate the lump sum Actuarial Equivalent of the amount in paragraph (C) using the Actuarial Equivalent factors set forth in Section 1.08 for lump sum present value calculations.

The result is equal to the Participant's Opening Balance. Notwithstanding the foregoing, the Participant's FAP Benefit shall not be reduced pursuant to subparagraph (C) above if the Participant's Calculation Date is on or before January 1, 2000. For purposes of the calculation set forth in this subsection, a Participant's "Calculation Date" is the date three years prior to the first day of the month following the date on which the Participant would reach his full Social Security Retirement Age. Notwithstanding the foregoing, in the case of a Participant who first became a Participant prior to January 1, 1989, solely for purposes of ensuring that the Opening Balance is no less than such Participant's minimum benefit amount earned prior to January 1, 1989, the Calculation Date shall be modified as follows: (1) for Employees hired between January 1, 1976 and January 1, 1989, the Calculation Date is the first day of the month coinciding with or next following the Participant's 62nd birthday; or (2) for Employees hired prior to January 1, 1976, the Calculation Date is the first day of the month coinciding with or next following the Participant's 65th birthday.

5.04 Pay-Based Credits. Effective as of the date a Participant becomes an AB I Participant and up until the time that the Participant has a Termination of Service or otherwise stops accruing a benefit under the AB I Benefit provisions (such as due to a transition to the AB II Benefit), a Pay-Based Credit shall accrue to his or her AB I Account as of the last day of each Plan Year. The amount of the Pay-Based Credit shall equal a percentage of the Participant's Compensation for the Plan Year, plus an additional percentage of the Participant's Compensation in excess of one-half of the Taxable Wage Base for the Plan Year. The determination of Pay-Based Credits shall be based on the sum of the Participant's age and Point Service in accordance with the following table:

Age Plus Point Service	Percentage of Compensation	Percentage of Compensation Above ½ Taxable Wage Base
Fewer than 45	5.0%	2.0%
45-59	6.5%	2.0%
60-74	8.0%	2.0%
75 and over	10.0%	2.0%

For purposes of this subsection, a Participant's age plus Point Service is calculated as follows:

(i) A Participant's age means the time period from the first day of the month following the date of the Participant's birth to the January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated.

(ii) A Participant's Point Service as of January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated is added to the Participant's age, calculated as described in (i) above.

(iii) The sum calculated in (ii) above, as rounded down into a whole integer, applies for purposes of this Section 5.04 for such Plan Year.

For the Plan Year that an AB I Participant has a Termination of Service, such AB I Participant shall receive a Pay-Based Credit based on Compensation and Point Service earned through the date of the Termination of Service.

5.05 Interest Credits. Interest Credits shall be credited to a Participant's AB I Account for each Plan Year as of each December 31, based on the balance of the AB I Account as of the last day of the prior Plan Year (after Pay-Based Credits and Interest Credits are credited for that prior Plan Year). The rate used for determining

Interest Credits (the "Interest Credit Rate") shall be equal to the annual rate of interest on 30-year Treasury Securities, as determined and published by the Internal Revenue Service pursuant to Notice 2002-26, 2002-15 I.R.B. 743, for the month of September immediately preceding the first day of the Plan Year, but not less than 4 percent. The additional following provisions apply:

(a) For Year Payment Commences. In the case of a Participant who receives or begins to receive a distribution of his AB I Benefit prior to December 31 of a Plan Year, Interest Credits for such Plan Year shall be credited on a prorated basis to his AB I Account for the period from the prior December 31 until the date when the distribution is paid or commences. The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an Employee and the denominator of which is 12.

(b) For Initial Year of Participation. In the case of a Participant who becomes an AB I Participant during a Plan Year, Interest Credits shall be credited on a prorated basis based on the Opening Balance determined pursuant to Section 5.03(b). The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an AB I Participant and the denominator of which is 12.

(c) Interest Crediting After Termination. In the case of a Participant who has a Termination of Service and who is not vested in his AB I Account, Interest Credits shall not be credited to such Participant's AB I Account after such Termination of Service and shall not be credited for the period of absence from employment in the event the Participant is subsequently reemployed. If the Participant is subsequently reemployed, the Plan shall begin to credit Interest Credits to the Participant's Account (whether vested or nonvested) effective as of the date of the Participant's reemployment (however, for any Next Gen Employee, no additional Pay-Based Credits shall accrue). In the case of a Participant who has a Termination of Service and who is vested in his AB I Account, Interest Credits shall continue to be credited to such Participant's AB I Account as provided above in this Section up until the date the Participant begins distribution of his benefit.

(d) Market Rate of Return Rules. The Interest Credit Rate described above is intended not to exceed a "market rate of return" as set forth in Code Section 411(b)(5)(B) and as further described in Proposed Treasury Regulation Section 1.411(b)(5)-1(d) and may be modified in a future amendment if required by finalized Treasury Regulations or other guidance. In addition, upon the termination of the Plan, the following shall apply: (1) the rate of interest used to determine accrued benefits under the Plan shall be equal to the average of rates of interest used under the Plan during the 5-year period ending on the termination date; and (2) the interest rate and mortality table used to determine the amount of any benefit under the Plan payable in the form of an annuity payable at Normal Retirement Age shall be the rate and table specified under the Plan for such purpose as of the termination date, except that if such interest rate is a variable rate, the interest rate shall be determined under the rules of subclause (1).

5.06 Protected Benefit for an AB I Participant. If a Participant transfers from the FAP Benefit provisions to the AB I Benefit provisions (such as pursuant to one of the election periods set forth in Schedule II), then such Participant's Accrued Benefit shall be no less than the Accrued Benefit that would have been payable (expressed as a Single Life Annuity payable at the Participant's Normal Retirement Date) under the provisions of the Plan in effect on the Conversion Date established for the applicable Participant election. This Protected Benefit provision shall continue to apply with respect to any AB I Participant that subsequently transfers to become an AB II Participant.

ARTICLE VI

FAP BENEFIT

6.01 Applicability of Article. This Article VI sets forth the benefit accrual for any Participant who was a FAP Participant under the Plan at some point prior to the Effective Date. No additional benefit accruals under the Plan shall be governed by this Article VI. This Article VI also sets forth the provisions necessary to determine a Protected Benefit based on a prior FAP Benefit.

Unless a Participant is an AB II Participant under Article IV or an AB I Participant under Article V, the provisions of this Article shall apply in determining the Accrued Benefit for any Participant who was described as follows:

(a) an Employee who first became an Eligible Employee prior to January 1, 2000;

(b) a Union Employee hired prior to January 1, 2008, if the applicable collective bargaining agreement provided for benefit accruals to be determined under this Article VI; and

(c) a Union Employee hired prior to January 1, 2008, if the applicable collective bargaining agreement allowed him to elect the FAP Benefit under Article VI or the AB I Benefit under Article V, and the Participant elected to have benefit accruals determined under this Article VI.

In accordance with Section 6.02(b), the provisions of this Article VI shall only apply in determining a Participant's Accrued Benefit with respect to the period up to and including his Conversion Date.

This Article VI shall not apply to (1) any Exempt Employee accruing a benefit under the Plan on or after January 1, 2011; (2) any Disabled Exempt Employee accruing a benefit under the Plan on or after January 1, 2012; and (3) any Non-Exempt Employee (including any Disabled Non-Exempt Employee) accruing a benefit under the Plan on or after January 1, 2013.

6.02 FAP Benefit.

(a) General Rule. Except as otherwise provided in this Section and subject to the limitations of Article XIII, a Participant's FAP Benefit is a monthly benefit, calculated as a Single Life Annuity commencing on the Participant's Normal Retirement Date, that is equal to one-twelfth of the sum of:

(i) 1.15 percent of the Participant's Final Average Pay that does not exceed one-half of the Taxable Wage Base for the Plan Year in which the Participant's Termination of Service occurs, multiplied by the Participant's years of Credited Service (up to a maximum of 30 years);

(ii) 1.50 percent of the Participant's Final Average Pay in excess of one-half of the Taxable Wage Base determined under paragraph (i), multiplied by the Participant's years of Credited Service (up to a maximum of 30 years); and

(iii) 0.50 percent of the Participant's Final Average Pay multiplied by the Participant's years of Credited Service in excess of 30 years (up to a maximum of ten years).

(b) Date of Determination. Notwithstanding subsection (a), in the case of a Participant who transitions to the AB II Benefit or the AB I Benefit (either automatically or by election), the Participant's FAP

Benefit (for purposes of determining the Protected Benefit or, if applicable, a frozen FAP Benefit) shall be determined without regard to any Compensation paid or Credited Service earned after his Conversion Date (other than Compensation or Credited Service attributable to any subsequent period when the Participant again becomes a FAP Participant, if applicable).

6.03 Supplemental Retirement Income.

(a) Eligibility for Benefit. A Participant shall be entitled to receive a supplemental retirement benefit if he:

(i) is described in Section 6.01;

(ii) attains his Early Retirement Age while employed by the Company or a Related Employer;

(iii) elects to begin receiving benefits prior to his 62nd birthday; and

(iv) is a FAP Participant at the time of his Termination of Service.

Notwithstanding the foregoing, pursuant to the transfer provisions in Section 3.04(b)(ii), any Employee with a frozen FAP Benefit under the Plan shall not be entitled to a supplemental benefit with regards to that frozen benefit unless such Employee has met the eligibility requirements set forth in this subsection on or before transferring to a Related Employer or to a position within the Employer that is subject to a different pension plan.

(b) Amount of Supplemental Benefit. A Participant who becomes entitled to a supplemental benefit under this Section shall be entitled to a monthly benefit equal to $16.00 multiplied by the Participant's years of Credited Service (up to a maximum of 30 years). This supplemental benefit shall be paid from the Participant's Benefit Commencement Date to the earlier of:

(i) the date on which the Participant is first eligible to receive benefits under the Social Security Act; or

(ii) the date of the Participant's death.

(c) Payment. If a Participant elects to receive his FAP Benefit in a lump sum pursuant to Section 10.03, the Actuarial Equivalent of the supplemental benefit determined under this Section shall be paid to the Participant in a single lump sum. If a Participant elects to receive his FAP Benefit in any annuity form provided in Article X, the supplemental benefit determined under this Section shall be paid in a Single Life Annuity.

ARTICLE VII

RETIREMENT BENEFITS

7.01 Normal Retirement Benefit.

(a) Eligibility. Subject to the provisions of Article X, a Participant who attains Normal Retirement Age while employed by the Company or a Related Employer shall be eligible for a Normal Retirement Benefit under the Plan. This "Normal Retirement Benefit" shall be calculated as a Single Life Annuity commencing on the Participant's Normal Retirement Date. If a Participant remains employed after his Normal Retirement Date, benefit payments under this Section may be suspended under Article XI.

(b) Amount and Payment. Except as otherwise provided in this Section and subject to the limitations of Article XIII, a Participant who becomes entitled to receive a Normal Retirement Benefit under this Section shall be entitled to a monthly benefit equal to the Participant's Accrued Benefit. A Participant's Normal Retirement Benefit shall be paid after a Termination of Service in accordance with Article X.

(c) Minimum Accrued Benefit. Notwithstanding any provision to the contrary, in accordance with Code Section 411(a)(9), in no event shall the Normal Retirement Benefit be less than the largest periodic benefit that would have been payable to the Participant upon Termination of Service at or prior to Normal Retirement Age under the Plan, exclusive of social security supplements (if any) and the value of disability benefits (if any) not in excess of the Normal Retirement Benefit. For purposes of comparing periodic benefits in the same form, commencing prior to and at Normal Retirement Age, the greater benefit is determined by converting the benefit payable prior to Normal Retirement Age into the same form of annuity benefit payable at Normal Retirement Age and comparing the amount of such annuity payments. In the case of a top-heavy plan, the Normal Retirement Pension shall not be smaller than the minimum benefit to which the Participant is entitled under Article XIX.

7.02 Late Retirement Benefit.

(a) Eligibility. Subject to the provisions of Article X, a Participant who remains an Employee beyond his Normal Retirement Date shall be eligible for a late retirement benefit under the Plan. This late retirement benefit shall be calculated as a Single Life Annuity commencing on the Participant's Late Retirement Date.

(b) Amount and Payment. Except as otherwise provided in this Section and subject to the limitations of Article XIII, a Participant who becomes eligible to receive a late retirement benefit under this Section shall be entitled to a monthly benefit equal to the Participant's Accrued Benefit. In no event shall a late retirement benefit under this Section be less than the greatest monthly Normal Retirement Benefit the Participant would have been entitled to receive if he had elected to retire at Normal Retirement Age. A Participant's late retirement benefit shall be paid after a Termination of Service in accordance with Article X and Article XI.

(c) Adjustment for Required Minimum Distributions. In the case of any Participant (such as a "five percent owner" as defined in Code Section 416) whose retirement benefits commence prior to his Termination of Service pursuant to Section 10.07, the Participant's benefit shall be adjusted, if appropriate, as of January 1 of each year beginning after the Participant's Benefit Commencement Date to reflect additional accruals under the Plan for the immediately preceding calendar year.

7.03 Early Retirement Benefit.

(a) Eligibility. Subject to the provisions of Article X, a Participant who has a Termination of Service on or after attaining his Early Retirement Age, but before such Participant reaches Normal Retirement Age, shall be eligible for an "Early Retirement Benefit" calculated as a Single Life Annuity commencing on his Early Retirement Date. If a Participant is reemployed after his Early Retirement Date, benefit payments under this Section may be suspended under Article XI.

(b) Amount and Payment. Subject to the limitations of Article XIII, the Early Retirement Benefit shall be determined and paid depending on whether the Participant is an AB II Participant, AB I Participant or FAP Participant as described below. A Participant's Early Retirement Benefit shall be paid commencing on his Early Retirement Date in accordance with Article X.

(i) For AB II or AB I Participants. The Early Retirement Benefit for any AB II Participant or any AB I Participant, as applicable, shall be a monthly benefit equal to the Actuarial Equivalent of the Participant's Accrued Benefit determined as of the Benefit Commencement Date, including consideration of a Protected Benefit calculation (if applicable) which applies the early retirement reduction factors set forth in subparagraph (ii) below.

(ii) For FAP Participants. The Early Retirement Benefit for any FAP Participant shall be a monthly benefit equal to the Participant's FAP Benefit reduced by 0.25% for each month by which the Participant's Early Retirement Date precedes the first day of the month following the date that is three years prior to his Social Security Retirement Age. The calculation set forth in this subsection (ii) shall also apply for calculating the Protected Benefit (if applicable) of an AB II or AB I Participant retiring under this Section 7.03.

(iii) Special Grandfathered Minimum Benefit Reductions. For a FAP Participant who first became a Participant prior to January 1, 1989, solely for purposes of calculating such Participant's minimum benefit amount earned prior to January 1, 1989, the Early Retirement Benefit shall be reduced as follows.

(A) For Employees hired between January 1, 1976 and January 1, 1989, by 0.25% for each month by which the Participant's Early Retirement Date precedes the first day of the month coinciding with or next following the date that is three years prior to the Participant's 65th birthday.

(B) For Employees hired prior to January 1, 1976, by 0.25% for each month by which the Participant's Early Retirement Date precedes the first day of the month coinciding with or next following the Participant's 65th birthday.

(c) Voluntary Retirement Programs. Notwithstanding the preceding provisions, special Early Retirement Benefits shall be calculated pursuant to the applicable Appendix for an eligible Participant who elects to retire under a Voluntary Incentive Retirement Program or the Columbia 2002 Workforce Reduction Window offered by the Employer and who otherwise satisfies the requirements of the applicable Appendix.

7.04 Disability Benefit. If a Participant becomes Disabled while employed by the Employer prior to the attainment of his Normal Retirement Age, he will be deemed to receive Credited Service, Point Service and Compensation for the duration of the period during which he remains Disabled (but in no event after his attainment of his Normal Retirement Age) in accordance with the Compensation and service crediting provisions set forth in Articles I and II, respectively. Accordingly, with respect to an AB II Participant or an

AB I Participant, the Plan Administrator shall continue to maintain an AB II or AB I Account, as applicable, on behalf of the Participant during such period of Disability, with Pay-Based Credits and Interest Credits continuing to be made to the Participant's AB II or AB I Account, as applicable, for the duration of the Disability. Moreover, with respect to a FAP Participant, a Participant who becomes Disabled shall continue to receive Credited Service for purposes of calculating the FAP Benefit in accordance with Article II. Upon a Disabled Participant attaining his Normal Retirement Date or Early Retirement Date, such Participant shall be entitled to receive a benefit in accordance with Section 7.01 or Section 7.03, as applicable. Further, if the Participant is deemed to have a Termination of Service (prior to Normal or Early Retirement Age), such Participant shall be entitled to receive a benefit in accordance with the provisions of Article VIII.

7.05 Nonduplication of Benefits. The amount of a Participant's retirement benefits shall be reduced by any retirement income payable from any source other than the Trust, to which a Participant is entitled under any tax qualified defined benefit plan of a Related Employer, attributable to a period of employment for which he receives a benefit from the Plan. For the purpose of computing the amount of such reduction, if the payment of other retirement income is to commence other than at the Employee's Normal Retirement Date under this Plan, or is to be made on a basis other than a retirement income for life, such other payment shall be recomputed to its Actuarial Equivalent value on the basis of a retirement income for life commencing on such Normal Retirement Date.

ARTICLE VIII

TERMINATION OF SERVICE; PARTICIPANT VESTING

8.01 Termination of Service Prior to Normal or Early Retirement or Death. Upon Termination of Service prior to a Participant's Normal or Early Retirement Date (for any reason other than death), such Participant shall be entitled to a Vested retirement benefit (a "Deferred Vested Benefit") that has become nonforfeitable in accordance with the provisions of Section 8.02. This Deferred Vested Benefit shall be calculated as a Single Life Annuity and shall be determined and paid depending on whether the Participant is an AB II Participant, AB I Participant or FAP Participant as described below. If a Participant is reemployed after commencing benefits, benefit payments under this Section may be suspended under Article XI. In addition to the payment provisions set forth below, a Participant's Deferred Vested Benefit shall be paid in accordance with Article X and subject to the limitations of Article XIII.

(a) For AB II or AB I Participants.

(i) Timing. An AB II Participant or AB I Participant may elect to begin receiving the Deferred Vested Benefit as soon as administratively practicable (generally the first of the month) following the Participant's Termination of Service, or the first day of any month thereafter. Such date shall be considered the Participant's "Vested Retirement Date."

(ii) Amount. The Deferred Vested Benefit of a terminated AB II Participant or AB I Participant shall be calculated as follows:

(A) If the Participant commences the Deferred Vested Benefit on his or her Normal Retirement Date, the Participant shall be entitled to a monthly benefit equal to his Accrued Benefit.

(B) If the Participant commences the Deferred Vested Benefit on or after reaching Early Retirement Age but before Normal Retirement Age, the Participant shall be entitled to a monthly benefit equal to the Actuarial Equivalent of the Participant's Accrued Benefit determined as of the Benefit Commencement Date, including consideration of a Protected Benefit calculation (if applicable) which applies the early retirement reduction factors set forth in Section 8.01(b)(ii)(B).

(C) If the Participant commences the Deferred Vested Benefit prior to reaching an Early or Normal Retirement Age, the Participant shall be entitled to a monthly benefit equal to the Actuarial Equivalent of the Participant's Accrued Benefit determined as of the Benefit Commencement Date, including consideration of a Protected Benefit calculation which applies the Actuarial Equivalent factors set forth in Section 1.08.

(b) For FAP Participants.

(i) Timing. If a FAP Participant has a Termination of Service prior to attaining Normal or Early Retirement Age, such Participant may elect to begin receiving the Deferred Vested Benefit on the first day of any month following attainment his or her Early Retirement Age. Such date shall be considered the Participant's "Vested Retirement Date."

(ii) Amount. The Deferred Vested Benefit of a terminated FAP Participant shall be calculated as follows:

(A) If the Participant commences the Deferred Vested Benefit on his or her Normal Retirement Date, the Participant shall be entitled to a monthly benefit equal to his Accrued Benefit.

(B) If the Participant commences the Deferred Vested Benefit on or after reaching Early Retirement Age but before Normal Retirement Age, the Deferred Vested Benefit for any FAP Participant (or with respect to the calculation of any Protected Benefit, if applicable) shall be a monthly benefit equal to the Participant's FAP Benefit reduced by 0.25% for each month by which the Participant's Benefit Commencement Date precedes the first day of the month following the date that is three years prior to his Social Security Retirement Age.

8.02 Vesting.

A Participant's Accrued Benefit is 100% Vested upon and after his attaining Normal Retirement Age (if employed by a Related Employer on or after that date). If a Participant's employment terminates prior to Normal Retirement Age, then for each Year of Vesting Service, such Participant shall receive a Vested percentage of his Accrued Benefit equal to the following:

Years of Vesting Service	Percent of Vested Accrued Benefit
Less than 3	0%
At least 3 or more	100%

Notwithstanding the foregoing, for Participants terminating employment prior to January 1, 2008, the Plan applied a 5-year cliff vesting schedule, rather than the 3-year cliff vesting schedule set forth above.

8.03 Included Years of Vesting Service.

All of a Participant's years of Vesting Service shall be taken into account for purposes of the Plan, except as set forth herein. If a Participant with a 0% Vested Accrued Benefit incurs a Break in Service, the Plan Administrator shall disregard his years of Vesting Service before the Break in Service if the number of the Employee's consecutive one-year Breaks in Service equals or exceeds the greater of 5 or the aggregate number of the Employee's years of Vesting Service prior to such break. The aggregate number of years of Vesting Service before a Break in Service does not include any years of Vesting Service not required to be taken into account under this exception by reason of any prior Break in Service. If the Plan Administrator disregards the Participant's years of Vesting Service under this exception, the Plan forfeits his pre-Break in Service Accrued Benefit.

8.04 Deemed Cash-Out Provision for Non-Vested Participants.

A "deemed" cash-out rule applies to a 0% Vested Participant. The Plan Administrator shall treat a 0% Vested Participant as having received a cash-out distribution on the date of the Participant's Termination of Service. Upon the reemployment of such a Participant prior to five (5) consecutive one-year Breaks in Service, the Participant's entire Accrued Benefit shall be restored. However, if such Participant is not re-employed with the Employer prior to five (5) consecutive one-year Breaks in Service, the Plan Administrator shall disregard the Participant's prior Accrued Benefit when determining the Participant's Accrued Benefit earned after his re-employment.

ARTICLE IX

DEATH BENEFITS

9.01 Death On Or After Benefit Commencement Date. Upon the death of any Participant on or after his Benefit Commencement Date, whether or not the Participant had actually received the first payment of his benefit, the death benefit, if any, payable to the Participant's Beneficiary (including a joint annuitant) shall be determined in accordance with the payment form selected by the Participant.

9.02 Death Prior to Benefit Commencement Date. If a Participant dies before his Benefit Commencement Date but after attaining a vested right to his Accrued Benefit, a death benefit may be payable under this Article. This death benefit shall be separately determined and paid depending on whether the Participant is an AB II Participant, AB I Participant or FAP Participant as described below.

(a) Death Benefit for AB II or AB I Participants.

(i) Eligibility. Upon the death of either an AB II Participant or an AB I Participant (regardless of whether single or married) prior to his or her Benefit Commencement Date, a death benefit shall be paid in accordance with this Section 9.02(a) to such Participant's Spouse or other Beneficiary or Beneficiaries, subject to the spousal consent requirement set forth in this Article.

(ii) Amount and Form.

(A) Spousal Death Benefit. Unless a valid waiver election has been made pursuant to Section 9.04, the Plan Administrator shall direct the Trustee to distribute the death benefit of a married AB II Participant or AB I Participant, as applicable, to such Participant's surviving Spouse as a Preretirement Survivor Annuity. A "Preretirement Survivor Annuity" is a Single Life Annuity payable for the life of the surviving Spouse equal to the greater of the following:

1. the Actuarial Equivalent of the Participant's AB II Account or AB I Account, as applicable, at the time payments commence; or

2. the survivor annuity portion of the QJSA set forth in Section 10.01 calculated in accordance with Code Section 417(c) and based on the Participant's Accrued Benefit (including consideration of the Participant's Protected Benefit).

In lieu of this monthly annuity, the Spouse Beneficiary can elect to receive the Participant's AB II Account or AB I Account, as applicable, payable as a single lump sum payment.

(B) Non-Spousal Death Benefit. If the Participant is not married or has made a valid waiver election pursuant to Section 9.04, the death benefit payable to a non-Spouse Beneficiary shall equal the Participant's AB II Account or AB I Account, as applicable, and shall be paid in the form of a single lump sum payment.

(iii) Timing of Payment. Any lump sum death benefit shall be paid as soon as practicable after the Participant's death. The Preretirement Survivor Annuity described in paragraph (ii) above

shall commence as of the first day of the month following the Participant's death. Alternatively, a surviving Spouse may elect to defer commencement of such annuity until the first day of any calendar month coinciding with or next following the date on which the Participant would have attained age 65, but no later than that date. Notwithstanding the foregoing, any death benefit payments shall be subject to the minimum distribution requirements of Section 10.07.

(b) Death Benefit for FAP Participants.

(i) Eligibility. If a FAP Participant dies before his or her Benefit Commencement Date and is married at the time of his or her death, a death benefit shall be paid in accordance with this Section 9.02(b) to such Participant's Spouse. If a FAP Participant dies before his or her Benefit Commencement Date and is not married at the time of his or her death, a death benefit shall be paid only in the event that the FAP Participant has one or more surviving Children under the age of 21, in accordance with this Section 9.02(b). No death benefit shall be paid to any other non-married FAP Participant.

(ii) Recipient(s) and Form of Payment. The benefit payable pursuant to this subsection (b) shall be paid in the form of a monthly benefit payable to the surviving Spouse for his or her lifetime. If the surviving Spouse dies before the Participant's youngest surviving Child attains age 21, the monthly benefit calculated under this subsection (b) shall continue to be paid until the youngest surviving Child attains age 21. Alternatively, if the FAP Participant has no surviving Spouse, the monthly benefit calculated pursuant to this subsection (b) shall be paid to the Participant's surviving Children who are under age 21, shall continue as to each surviving Child until such surviving Child reaches age 21, and shall cease when the youngest surviving Child attains age 21. Each payment made to the Participant's Children shall be divided equally among the surviving Children who are under age 21 at the time the payment is made.

(iii) Amount and Commencement. The benefit payable under this subsection (b) shall be determined and paid as follows:

(A) Death While Employed. If a FAP Participant dies while actively employed, on an Authorized Leave of Absence, or receiving benefits under the long-term disability plan maintained by the Employer, and subject also to the provisions of Section 9.03(c), a preretirement death benefit shall be paid to the surviving Spouse or eligible Child or Children in an amount equal to 75% of the Participant's FAP Benefit, reduced by 0.25% for each full month in excess of 60 months by which the Participant's age exceeded the Spouse's age. In no event, however, shall the benefit payable to a surviving Spouse be less than the value of the benefit payable pursuant to paragraph (B) below. Payment of the death benefit described in this paragraph A shall commence as of the first day of the month following the date of the Participant's death.

(B) Death After Termination. In the case of any FAP Participant not described in paragraph (A) above, a preretirement death benefit shall be paid in an amount equal to a survivor annuity (calculated using the FAP Participant's date of birth where there is no surviving Spouse) as if the Participant had –

1. Survived to his or her Earliest Retirement Age;

2. Retired with an immediate Qualified Joint and Survivor Annuity with respect to the FAP Benefit at his Earliest Retirement Age; and

3. Died on the day after he would have attained his Earliest Retirement Age.

"Earliest Retirement Age" means the earliest date on which, under the Plan a Participant could elect to receive a retirement benefit.

With respect to the death benefit described in this subsection B, if there is no surviving Spouse (*i.e.*, where the death benefit is payable only to one or more surviving Children who are under age 21), payment shall commence as of the first day of the month following the date of the Participant's death, to the extent administratively practicable. If payments do not commence as of the first day of the month following the date of the Participant's death, the first payment to the surviving Child or Children shall be grossed up to include any retroactive payments that would have been made if payments had commenced on such date.

Where there is a surviving Spouse, the death benefit payments described in this subsection B shall commence as of the first day of the month following the date of the Participant's death, or if later, as of the first day of the month following the date on which the Participant would have attained Earliest Retirement Age. Alternatively, a surviving Spouse may elect to defer commencement of the death benefit described in this subsection B until the first day of any calendar month preceding or coinciding with the date on which the Participant would have attained Normal Retirement Age, but not later than that date. The monthly amount of any death benefit that commences after the Participant's Earliest Retirement Age shall be increased (as if the Participant had deferred commencement of the benefit) to reflect the surviving Spouse's deferral.

Notwithstanding the foregoing, with respect to death benefit payments made prior to January 1, 2011, the death benefit calculated under this subsection B shall equal 50% of the Participant's FAP Benefit, calculated in a similar manner to the death benefit set forth in subsection A (*i.e.*, no application of actuarial or early retirement reduction factors, but reduced by 0.25% for each full month in excess of 60 months by which the Participant's age exceeded the Spouse's age). Further, with respect to such death benefit payments made prior to January 1, 2011, because such death benefit does not reflect an actuarial or early retirement reduction, any delay in the commencement of the death benefit will not cause any actuarial increase or other adjustment to reflect such delay.

9.03 Additional Death Benefit Payment Provisions.

(a) Automatic Cash Outs. Notwithstanding anything in this Article to the contrary, if the Actuarial Equivalent present value of any death benefit payable under Section 9.02 is not greater than $5,000, such benefit shall be paid in one lump sum as soon as practicable following the death of the Participant. Such payment shall be in full settlement of the benefit that otherwise would be payable under this Article.

(b) Direct Rollover. In the case of any single sum distribution made under this Article, a surviving Spouse or non-Spouse Beneficiary may elect to have the distribution made in the form of a direct rollover pursuant to Section 10.10.

(c) HEART Act Provision. Notwithstanding anything in this Article to the contrary, in the case of a death occurring on or after January 1, 2007, if a Participant dies while performing qualified military service (as defined in Code Section 414(u)), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the Plan as if the Participant had resumed and then terminated employment on account of death.

9.04 Preretirement Survivor Annuity Requirements. In accordance with Section 9.02(a), if a married AB II Participant or married AB I Participant dies prior to his Benefit Commencement Date, the Plan Administrator shall direct the Trustee to distribute the married Participant's death benefit to the Participant's surviving Spouse as a Preretirement Survivor Annuity, unless a valid waiver election has been made pursuant to this Section 9.04.

(a) Notice Content. The Plan Administrator shall provide each AB II Participant or AB I Participant, within the notice period described in subsection (b), a written explanation of:

(i) the terms and conditions of the automatic Preretirement Survivor Annuity payable under the Plan;

(ii) the Participant's right to make, and the financial consequences of, an election to waive such annuity with respect to his AB I Benefit or AB II Benefit, as applicable;

(iii) the material features and relative values of the automatic and optional preretirement death benefits;

(iv) the rights of the Participant's Spouse regarding a waiver of the automatic Preretirement Survivor Annuity; and

(v) the right of a Participant to revoke a prior waiver of the annuity and the effect and financial consequences of a revocation.

(b) Notice Period. The Plan Administrator shall provide the notice described in subsection (a) within the period beginning on the first day the Participant commences participation in the Plan and ending on the close of the 12-month period following the date on which he becomes an AB I Participant or AB II Participant, as applicable. If a Participant incurs a Termination of Service prior to age 35, the notice shall be provided within one year following the Participant's Termination of Service. If a Participant again becomes an Eligible Employee after a Termination of Service prior to age 35, the Plan Administrator must again provide such notice within the 12-month period after the Participant resumes participation in the Plan as an AB I Participant or AB II Participant, as applicable.

(c) Waiver Procedures.

(i) General Rule. A married Participant who designates a Beneficiary other than his Spouse for the AB I Benefit or AB II Benefit, as applicable, must waive the automatic Preretirement Survivor Annuity in accordance with this Section. A Participant may waive the Preretirement Survivor Annuity, or revoke any such waiver, during the period that begins on the first day the Participant commences participation in the Plan and ends on the date of the Participant's death. The Participant's waiver must be in writing and on a form supplied by the Plan Administrator. The Participant's Spouse must consent in writing to the waiver and must acknowledge the effect and financial consequences of the waiver. The Spouse's consent must be witnessed by a notary public or a Plan representative.

(ii) Election Before Age 35. If a Participant designates a Beneficiary other than his Spouse before the first day of the Plan Year in which the Participant attains age 35, the designation shall become invalid as of the first day of such Plan Year. If the Participant dies on or after that date, any Preretirement Survivor Annuity payable with respect to his AB I Benefit or AB II Benefit, as applicable, shall be payable to the Participant's Spouse unless the Participant makes a new waiver of the automatic Preretirement Survivor Annuity in accordance with this Section on or after the first day of the Plan Year in which he attains age 35.

(iii) Exception to Consent Requirement. The consent of a Participant's Spouse shall not be required where—

(A) the Plan Administrator determines that the required consent cannot be obtained because there is no Spouse or the Spouse cannot be located;

(B) the Plan Administrator determines that the Participant is legally separated;

(C) the Plan Administrator determines that the Participant has been abandoned within the meaning of local law and there is a court order to that effect; or

(D) there exists any other circumstance (as determined by the Plan Administrator) prescribed by law as an exception to the consent requirement.

(iv) Revocation and Modification. A waiver made by a Participant may be revoked by the Participant in writing without the consent of his Spouse at any time during the waiver period. However, any subsequent waiver by a Participant under this Section must comply with the requirements of this Section.

(v) Validity of Spousal Consent. Any consent under this provision shall be valid only with respect to the Spouse who signs the consent or, if the Spouse's consent is excused by the Plan Administrator, the designated Spouse, but shall be irrevocable once given.

9.05 Beneficiary Designation.

Subject to the provisions of this Article and Article X, a Participant may from time to time designate, in writing, any person or persons, contingently or successively, to whom the Trustee shall pay the Participant's death benefit under the Plan. The Plan Administrator shall prescribe the form for the written designation of Beneficiary and, upon the Participant's filing the form with the Plan Administrator, the form effectively shall revoke all designations filed prior to that date by the same Participant.

This Section does not impose any special spousal consent requirements on the Participant's Beneficiary designation. However, in the absence of any required spousal consent (as required by Section 9.04 and Section 10.02) to the Participant's Beneficiary designation: (1) any waiver of the Qualified Joint and Survivor Annuity or of the Preretirement Survivor Annuity is not valid; and (2) if the Participant dies prior to his Benefit Commencement Date and has not designated the Participant's surviving Spouse as the sole, primary Beneficiary under the Beneficiary designation, then the Participant's Beneficiary designation will be invalid.

9.06 Failure of Beneficiary Designation.

If a Participant fails to name a Beneficiary in accordance with Section 9.05, if all Beneficiaries named by a Participant predecease him, or if any designation is not effective for any other reason as determined by the Plan Administrator, then the Participant's death benefit, shall be paid in the following order of priority, to:

(a) the Participant's surviving Spouse;

(b) the Participant's descendants, per stirpes; or

(c) the Participant's estate.

Prior to January 1, 2010, the determination of benefit payments in the event of a failure of a Beneficiary designation shall be made in accordance with the provisions set forth in the Plan 2006 Restatement.

9.07 Facility of Payment.

If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of minority, illness or infirmity, mental incompetency, or incapacity of any kind, the Plan Administrator may, in its discretion, direct the Trustee to take any one or more of the following actions:

(a) To apply such amount directly for the comfort, support and maintenance of such person;

(b) To reimburse any person for any such support theretofore supplied to the person entitled to receive any such payment;

(c) To pay such amount to any person selected by the Plan Administrator to disburse it for such comfort, support and maintenance, including without limitation, any relative who has undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution in whose care or custody the person entitled to the amount may be. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any savings or commercial bank of the Plan Administrator's choice.

(d) To pay any amount to be distributed to or for the benefit of a minor to a custodian named by the Plan Administrator and the Trustee under any Uniform Gifts or Transfers to Minors Act of the state of domicile of such minor, in the manner and form provided thereunder.

ARTICLE X

TIME AND METHOD OF PAYMENT OF BENEFITS

10.01 Automatic Form of Benefit Payment.

Unless a Participant makes a valid waiver election pursuant to Section 10.02 to receive an optional form of benefit under Section 10.03, a Participant shall be paid his benefit determined under Article VII or Article VIII in the form of a "qualified joint and survivor annuity" (the "QJSA").

(a) Unmarried Participants. If, as of the Benefit Commencement Date, the Participant is not married, the automatic form of payment is a Single Life Annuity (for purposes of the waiver requirements of Section 10.02, considered the unmarried participant's QJSA).

(b) Married Participants. If, as of the Benefit Commencement Date, the Participant is married, the automatic form of payment is a 50% Joint and Survivor Pop-up Annuity (the married Participant's QJSA). The married participant QJSA provides a monthly benefit to the Participant for his life and, upon the Participant's death, provides an annuity for the life of his surviving Spouse (to whom the Participant was married on his Benefit Commencement Date) in a monthly amount equal to 50% of the amount payable to the Participant during his or her life. In the event that the Spouse dies before the Participant and within 60 months after the Benefit Commencement Date, the amount of the Participant's monthly benefit shall be increased to the amount payable as if the Participant had elected a Single Life Annuity, effective as of the first day of the month following the Spouse's death (the "Pop-up Feature"). The married Participant QJSA shall be the Actuarial Equivalent of the Single Life Annuity, provided that the retirement benefit to the Participant shall not be reduced to reflect the value of the Pop-up Feature, and further provided that the QJSA shall in no event be less than the Actuarial Equivalent of the most valuable form of benefit available under the Plan, in accordance with Treasury Regulation Section 1.401(a)-(20).

10.02 Waiver Election - Qualified Joint And Survivor Annuity.

(a) Notice. Not earlier than 180 days (90 days, prior to January 1, 2007), but not later than 30 days (or 7 days, if the 30 day period is waived by the Participant), before the Participant's Benefit Commencement Date, the Participant shall be provided with a written explanation of the terms and conditions of the QJSA, the Participant's right to make, and the effect of, an election to waive the automatic QJSA form of benefit, the rights of the Participant's Spouse regarding the waiver election, the Participant's right to make, and the effect of, a revocation of a waiver election, and in accordance with Treasury Regulations Section 1.417(a)-3, a description of the relative values of the various optional forms of benefit under the Plan. In addition, effective January 1, 2007, the notice given to any Participant shall include a description of how much larger benefits will be if the Participant elects to defer the commencement of distributions (if applicable). The Plan does not limit the number of times the Participant may revoke a waiver of the QJSA or make a new waiver during the election period.

(b) Waiver Procedures. Any Participant that receives the notice described in subsection (a) may waive the QJSA and receive one of the optional forms of payment set forth in Section 10.03. The waiver election must be filed with the Plan Administrator within the 180-day period (a 90-day period prior to January 1, 2007) ending on the Participant's Benefit Commencement Date. A married Participant's waiver election is not valid unless (i) the Participant's Spouse (to whom the survivor annuity is payable under the Qualified Joint and Survivor Annuity) has consented in writing to the waiver election; (ii)

the election and consent specifies the optional form of benefit elected; (iii) the election and the consent designates a Beneficiary (if applicable); (iv) the Spouse's consent acknowledges the financial consequences of the consent; and (v) a notary public or the Plan Administrator (or its representative) witnesses the Spouse's consent.

(c) Exceptions to Spousal Consent. The consent of the Spouse is not required in the following instances: (i) the Participant elects the 66 2/3%, 75% (effective January 1, 2008), or 100% contingent annuity option under Section 10.03 with the Spouse as Beneficiary; (ii) the Plan Administrator determines the Participant does not have a Spouse or the Spouse cannot be located; (iii) the Plan Administrator determines that the Participant is legally separated; (iv) the Plan Administrator determines that the Participant has been abandoned within the meaning of the local law and there is a court order to that effect; or (v) there exists any other circumstance (as determined by the Plan Administrator) prescribed by law as an exception to the consent requirement. If the Participant's Spouse is legally incompetent to give consent, the Spouse's legal guardian (even if the guardian is the Participant) may give consent.

(d) Revocation and Modification. An election by a Participant to waive the QJSA may be revoked by the Participant in writing without the consent of his or her Spouse at any time during the election period. Any subsequent election by a Participant to waive the QJSA or any subsequent modification of a prior election must again comply with the consent requirements of subsection (b), unless the Spouse had previously executed a "blanket consent". The Spouse may execute a blanket consent to any form of payment designation or to any Beneficiary designation made by the Participant, if the blanket consent acknowledges the Spouse's right to limit that consent to a specific designation but, in writing, waives such right.

10.03 Optional Forms of Benefit Distribution. Subject to the waiver requirements of Section 10.02, the small benefit provisions of Section 10.04, and the minimum distribution provisions of Section 10.07, a Participant may elect to receive his benefit in the form of an optional method of payment set forth in this Section. Each optional form of payment shall be the Actuarial Equivalent of the applicable retirement benefit described in Article VII or the Deferred Vested Benefit described in Section 8.01. The election of an optional form of payment shall be in writing in the manner prescribed by the Plan Administrator, and, if in accordance with the conditions set forth below, shall become effective as of his Benefit Commencement Date. The election of an optional form of payment (or the automatic payment of the QJSA by default) cannot be revoked or changed once it has become effective.

The optional forms of payment under this Section vary depending on whether the Participant is an AB II Participant, AB I Participant, or FAP Participant as set forth below. In the case of certain Participants who transferred between benefit structures and had the prior benefit "frozen" or had a prior FAP Benefit provided through an annuity contract, the Participant shall separately elect the method of payment for his FAP Benefit and his AB I Benefit.

(a) AB II Participants and AB I Participants.

(i) Lump Sum Option – A single lump sum payment with no additional amounts after such payment if made.

(ii) Single Life Annuity Option – A monthly benefit payable to the Participant, with payments ending on the Participant's death.

(iii) 50% Joint and Survivor Pop-up Annuity Option. A reduced monthly benefit payable to the Participant (further reduced to reflect the value of the Pop-up Feature when not the QJSA) for the life of the Participant, with continuation payments as a survivor annuity for the remaining

life of the Beneficiary at a rate of 50% of the rate payable during the Participant's lifetime. In the event that the Beneficiary dies before the Participant, and within 60 months after the Benefit Commencement Date, the amount of the Participant's monthly benefit shall be increased to the amount payable as if the Participant had elected a Single Life Annuity, effective as of the first day of the month following the Beneficiary's death.

(iv) Joint and Survivor Annuity Options - A reduced monthly benefit payable to the Participant for life and to a surviving designated Beneficiary for the lifetime of the Beneficiary in an amount equal to 33 1/3%, 66 2/3%, 75% (effective January 1, 2008) or 100% (as elected by the Participant) of the rate payable during the Participant's lifetime.

(v) Five or Ten Year Certain and Life Annuity Option. A reduced monthly pension payable to the Participant for his life, but in the event the Participant dies before receiving 60 or 120 monthly payments, whichever number is specified in his election of this option, such payments shall continue to his Beneficiary for the balance of such 60 or 120 month period.

(b) FAP Participants.

(i) Lump Sum Option – A single lump sum payment with no additional amounts after such payment if made.

(ii) Single Life Annuity Option – A monthly benefit payable to the Participant, with payments ending on the Participant's death.

(iii) 50% Joint and Survivor Pop-up Annuity Option. A reduced monthly benefit payable to the Participant (further reduced to reflect the value of the Pop-up Feature when not the QJSA) for the life of the Participant, with continuation payments as a survivor annuity for the remaining life of the Beneficiary at a rate of 50% of the rate payable during the Participant's lifetime. In the event that the Beneficiary dies before the Participant, and within 60 months after the Benefit Commencement Date, the amount of the Participant's monthly benefit shall be increased to the amount payable as if the Participant had elected a Single Life Annuity, effective as of the first day of the month following the Beneficiary's death.

(iv) Joint and Survivor Annuity Options - A reduced monthly benefit payable to the Participant for life and to a surviving designated Beneficiary for the lifetime of the Beneficiary in an amount equal to 33 1/3%, 66 2/3%, 75% (effective January 1, 2008) or 100% (as elected by the Participant) of the rate payable during the Participant's lifetime.

10.04 Cash Out of Small Amounts.

Except as otherwise provided, all benefits under the Plan shall be payable in accordance with the provisions of this Article X. Furthermore, notwithstanding any provision to the contrary, the Participant must consent in writing to any distribution and to the form of distribution if: (1) the benefit payable to the Participant exceeds $5,000 and (2) the Plan Administrator directs the Trustee to make distribution to the Participant prior to his attaining Normal Retirement Age. Furthermore, the Participant's Spouse must consent in writing to the distribution if the Participant must consent.

Notwithstanding anything in this Article X to the contrary, if the Actuarial Equivalent of the benefit payable to the Participant is not greater than $5,000, the benefit shall be paid to the Participant in a lump sum as soon as practicable following the Participant's Benefit Commencement Date. Effective March 28, 2005, if the single lump sum Actuarial Equivalent of the benefit payable to a Participant exceeds $1,000, but does not exceed

$5,000, and the Participant does not elect to have such distribution paid directly to the Participant or in the form of a direct rollover in accordance with Section 10.10, then the Plan Administrator shall pay the distribution in a direct rollover to an individual retirement plan designated by the Plan Administrator.

10.05 Claim for Benefits.

Except as provided under Article IX and Section 10.04, no benefits shall be paid under the Plan unless the Participant entitled thereto submits to the Plan, in a form prescribed by the Plan Administrator, all of the information reasonably necessary for the payment of such benefits.

10.06 Restrictions on Distribution Timing. Notwithstanding anything in this Article to the contrary, unless the Participant otherwise elects in writing, distribution to the Participant shall not commence later than the sixtieth day after the close of the Plan Year in which occurs the latest of the following events:

(i) the Participant attains age 65;

(ii) the Participant attains the tenth anniversary of the date on which he became a Participant under the Plan; or

(iii) the Participant incurs a Termination of Service.

Notwithstanding the foregoing, the failure of a Participant and Spouse to consent to a distribution while a benefit is immediately distributable shall be deemed to be an election to defer commencement of payment of any benefit sufficient to satisfy this Section.

10.07 Minimum Distribution Requirements.

(a) General Rules.

(i) Precedence and Effective Date. The requirements of this Section shall take precedence over any inconsistent provisions of the Plan. This provisions of this Section will apply for purposes of determining required minimum distributions for calendar years beginning with the 2003 calendar year.

(ii) Requirements of Treasury Regulations Incorporated. All distributions required under this Section shall be determined and made in accordance with the Treasury Regulations under Code Section 401(a)(9).

(iii) Limitations on Distribution Periods. As of the first Distribution Calendar Year, distributions to a Participant, if not made in a single lump sum, may only be made over one of the following periods:

(A) the life of the Participant;

(B) the joint lives of the Participant and a Designated Beneficiary;

(C) a period certain not extending beyond the life expectancy of the Participant; or

(D) a period certain not extending beyond the joint life and last survivor expectancy of the Participant and a Designated Beneficiary.

(b) Time and Manner of Distribution.

(i) Required Beginning Date. The Participant's entire interest shall be distributed, or begin to be distributed, to the Participant no later than the Participant's Required Beginning Date.

(ii) Death of Participant Before Distributions Begin. If the Participant dies before distributions begin, the Participant's entire interest shall be distributed, or begin to be distributed, no later than as follows:

(A) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, distributions to the Spouse shall begin by December 31 of the calendar year immediately following the calendar year in which the Participant died, or by December 31 of the calendar year in which the Participant would have attained age 70-1/2, if later.

(B) If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, distributions to the Designated Beneficiary shall begin by December 31 of the calendar year immediately following the calendar year in which the Participant died.

(C) If there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, the Participant's entire interest shall be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(D) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary and the Spouse dies after the Participant but before distributions to the Spouse begin, this subsection (b)(ii), other than subsection (b)(ii)(A), shall apply as if the Spouse were the Participant.

For purposes of this subsection (b)(ii) and subsection (e)(ii), distributions are considered to begin on the Participant's Required Beginning Date (or, if subsection (b)(ii)(D) applies, the date distributions are required to begin to the Spouse under subsection (b)(ii)(A)). If annuity payments irrevocably commence to the Participant before the Participant's Required Beginning Date (or to the Participant's Spouse before the date distributions are required to begin to the Spouse under subsection (b)(ii)(A)), the date distributions are considered to begin is the date distributions actually commence.

(iii) Form of Distribution. Unless the Participant's interest is distributed in the form of an annuity purchased from an insurance company or in a single sum on or before the Required Beginning Date, as of the first Distribution Calendar Year, distributions shall be made in accordance with paragraphs (c), (d) and (e) of this Section. If the Participant's interest is distributed in the form of an annuity purchased from an insurance company, distributions thereunder shall be made in accordance with the requirements of Code Section 401(a)(9) and the regulations thereunder. Any part of the Participant's interest which is in the form of an individual account described in Code Section 414(k) shall be distributed in a manner satisfying the requirements of Code Section 401(a)(9) and the Treasury Regulations thereunder that apply to individual accounts.

(c) Determination of Amount to be Distributed Each Year.

(i) General Annuity Requirements. If the Participant's interest is paid in the form of annuity distributions under the Plan, payments under the annuity shall satisfy the following requirements:

(A) the annuity distributions shall be paid in periodic payments made at intervals not longer than one year;

(B) the distribution period shall be over a life (or lives) or over a period certain not longer than the period described in subsection (d) or (e);

(C) once payments have begun over a period certain, the period certain shall not be changed even if the period certain is shorter than the maximum permitted;

(D) payments shall either be nonincreasing or may increase only as follows:

1. by an annual percentage increase that does not exceed the annual percentage increase in a Eligible Cost-of-Living Index that is based on prices of all items and issued by the Bureau of Labor Statistics;

2. by a constant percentage of less than 5% per year, applied not less frequently than annually;

3. as a result of dividend or other payments that result from Actuarial Gains, in accordance with Treasury Regulations Section 1.401(a)(9)-6, Q&A-14(d)(3);

4. to the extent of the reduction in the amount of the Participant's payments to provide for a survivor benefit upon death, but only if the beneficiary whose life was being used to determine the distribution period described in subsection (d) below dies or is no longer the Participant's beneficiary pursuant to a qualified domestic relations order within the meaning of Code Section 414(p);

5. to provide final payment upon the Participant's death not greater than the excess of the actuarial present value of the Participant's accrued benefit (within the meaning of Code Section 411(a)(7)) calculated as of the annuity starting date using the applicable interest rate defined in Section 1.08 and the applicable mortality table defined in Section 1.08 (or, if greater, the total amount of employee contributions) over the total payments before the Participant's death;

6. to allow a beneficiary to convert the survivor portion of a joint and survivor annuity into a single sum distribution upon the Participant's death; or

7. to pay increased benefits that result from a Plan amendment.

(ii) Amount Required to be Distributed by Required Beginning Date. The amount that must be distributed on or before the Participant's Required Beginning Date (or, if the Participant dies before distributions begin, the date distributions are required to begin under subsection (b)(ii)(A) or (b)(ii)(B)) is the payment that is required for one payment interval. The second payment need not be made until the end of the next payment interval even if that payment interval ends in the next calendar year. Payment intervals are the periods for which

payments are received (*e.g.*, bi-monthly, monthly, semi-annually, or annually). All of the Participant's benefit accruals as of the last day of the first Distribution Calendar Year shall be included in the calculation of the amount of the annuity payments for payment intervals ending on or after the Participant's Required Beginning Date.

(iii) Additional Accruals After First Distribution Calendar Year. Any additional benefits accruing to the Participant in a calendar year after the first Distribution Calendar Year shall be distributed beginning with the first payment interval ending in the calendar year immediately following the calendar year in which such amount accrues.

(d) Requirements For Annuity Distributions That Commence During Participant's Lifetime.

(i) Joint Life Annuities Where the Beneficiary Is Not the Participant's Spouse. If the Participant's interest is being distributed in the form of a joint and survivor annuity for the joint lives of the Participant and a non-Spouse beneficiary, annuity payments to be made on or after the Participant's Required Beginning Date to the Designated Beneficiary after the Participant's death must not at any time exceed the applicable percentage of the annuity payment for such period that would have been payable to the Participant using the table set forth in Treasury Regulation Section 1.401(a)(9)-6, Q&A-2(c)(2), in the manner described in Q&A-2(c)(1), to determine the applicable percentage. If the form of distribution combines a joint and survivor annuity for the joint lives of the Participant and a non-Spouse beneficiary and a period certain annuity, the requirement in the preceding sentence shall apply to annuity payments to be made to the Designated Beneficiary after the expiration of the period certain.

(ii) Period Certain Annuities. Unless the Participant's Spouse is the sole Designated Beneficiary and the form of distribution is a period certain and no life annuity, the period certain for an annuity distribution commencing during the Participant's lifetime may not exceed the applicable distribution period for the Participant under the Uniform Lifetime Table set forth in Treasury Regulation Section 1.401(a)(9)-9, Q&A-2 for the calendar year that contains the annuity starting date. If the annuity starting date precedes the year in which the Participant reaches age 70, the applicable distribution period for the Participant is the distribution period for age 70 under the Uniform Lifetime Table set forth in Treasury Regulation Section 1.401(a)(9)-9, Q&A-2 plus the excess of 70 over the age of the Participant as of the Participant's birthday in the year that contains the annuity starting date. If the Participant's Spouse is the Participant's sole Designated Beneficiary and the form of distribution is a period certain and no life annuity, the period certain may not exceed the longer of the Participant's applicable distribution period, as determined under this subsection (d)(ii), or the joint life and last survivor expectancy of the Participant and the Participant's Spouse as determined under the Joint and Last Survivor Table set forth in Treasury Regulation Section 1.401(a)(9)-9, Q&A-3, using the Participant's and Spouse's attained ages as of the Participant's and Spouse's birthdays in the calendar year that contains the annuity starting date.

(e) Requirements for Minimum Distributions After the Participant's Death.

(i) Death After Distributions Begin. If the Participant dies after distribution of his or her interest begins in the form of an annuity meeting the requirements of this Section, the remaining portion of the Participant's interest will continue to be distributed over the remaining period over which distributions commenced.

(ii) Death Before Distributions Begin.

(A) Participant Survived by Designated Beneficiary. If the Participant dies before the date distribution of his interest begins and there is a Designated Beneficiary, the Participant's entire interest shall be distributed, beginning no later than the time described in subsection (b)(ii)(A) or (b)(ii)(B), over the life of the Designated Beneficiary or over a period certain not exceeding:

1. unless the annuity starting date is before the first Distribution Calendar Year, the life expectancy of the Designated Beneficiary determined using the Designated Beneficiary's age as of the Designated Beneficiary's birthday in the calendar year immediately following the calendar year of the Participant's death; or

2. if the annuity starting date is before the first Distribution Calendar Year, the life expectancy of the Designated Beneficiary determined using the Designated Beneficiary's age as of the Designated Beneficiary's birthday in the calendar year that contains the annuity starting date.

(B) No Designated Beneficiary. If the Participant dies before the date distributions begin and there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, distribution of the Participant's entire interest shall be completed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(C) Death of Surviving Spouse Before Distributions to Surviving Spouse Begin. If the Participant dies before the date distribution of his interest begins, the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, and the surviving Spouse dies before distributions to the surviving Spouse begin, this subsection (e) shall apply as if the surviving Spouse were the Participant, except that the time by which distributions must begin shall be determined without regard to subsection (b)(ii)(A).

(f) Changes to Annuity Payment Period.

(i) Permitted Changes. An annuity payment period may be changed only in association with any annuity payment increase described in Section 10.07(c)(i)(D) above or if the conditions of Section 10.07(f)(iii) below are satisfied.

(ii) Reannuitization. An annuity payment period may be changed and the annuity payments modified in accordance with that change if the conditions in Section 10.07(f)(iii) below are satisfied and:

(A) the modification occurs when the Participant retires or in connection with a Plan termination;

(B) the payment period prior to modification is a period certain without life contingencies; or

(C) the annuity payments after modification are paid under a qualified joint and survivor annuity over the joint lives of the Participant and a Designated Beneficiary, the Participant's Spouse is the sole Designated Beneficiary, and the modification occurs in connection with the Participant's becoming married to such Spouse.

(iii) Conditions. The conditions of this Section 10.07(f) are satisfied if:

(A) the future payments after the modification satisfy the requirements of Code Section 401(a)(9), and this Section (determined by treating the date of the changes as a new annuity starting date and the actuarial present value of the remaining payments prior to modification as the entire interest of the Participant);

(B) for purposes of Code Sections 415 and 417, the modification is treated as a new annuity starting date;

(C) after taking into account the modification, the annuity (including all past and future payments) satisfies the requirements of Code Section 415 (determined at the original annuity starting date, using the interest rates and mortality tables applicable to such date); and

(D) the end point of the period certain, if any, for any modified payment period is not later than the end point available to the employee at the original annuity starting date under Code Section 401(a)(9) and this Section.

(g) Payments to a Surviving Child.

(i) Special rule. For purposes of this Section, payments made to a Participant's surviving child until the child reaches the age of majority (or dies, if earlier) shall be treated as if such payments were made to the surviving Spouse to the extent the payments become payable to the surviving Spouse upon cessation of the payment to the child.

(ii) Age of Majority. For purposes of this Section, a child shall be treated as having not reached the age of majority if the child has not completed a specified course of education and is under the age of 26. In addition, a child who is disabled within the meaning of Code Section 72(m)(7) when the child reaches the age of majority shall be treated as having not reached the age of majority so long as the child continues to be disabled.

(h) Definitions.

(i) Actuarial Gain. The difference between an amount determined using the actuarial assumptions (*i.e.*, investment return, mortality, expense and other similar assumptions) used to calculate the initial payments before adjustment for any increases and the amount determined under the actual experience with respect to those factors. Actuarial Gain also includes differences between the amount determined using actuarial assumptions when an annuity was purchased or commenced and such amount determined using actuarial assumptions used in calculating payments at the time the Actuarial Gain is determined.

(ii) Designated Beneficiary. The individual who is designated as the beneficiary under the Plan and is the Designated Beneficiary under Code Section 401(a)(9) and Treasury Regulation Section 1.401(a)(9)-4.

(iii) Distribution Calendar Year. A calendar year for which a minimum distribution is required. For distributions beginning before the Participant's death, the first Distribution Calendar Year is the calendar year immediately preceding the calendar year that contains the Participant's Required Beginning Date. For distributions beginning after the Participant's death, the first

Distribution Calendar Year is the calendar year in which distributions are required to begin pursuant to subsection 10.07(b).

(iv) Eligible Cost-of –Living Index. An index described in paragraphs (b)(2), (b)(3) or (b)(4) of Treasury Regulation Section 1.401(a)(9)-6, Q&A-14.

(v) Life Expectancy. For purposes of this Section, life expectancy shall be computed by using the Single Life Table in Treasury Regulation Section 1.401(a)(9)-9, Q&A-1.

(vi) Required Beginning Date. For purposes of this Section, April 1 of the calendar year following the later of the calendar year in which the Participant (1) attains age 70-1/2, or (2) terminates employment with the Company, unless he is a five percent owner (as defined in Code Section 416) at any time during the Plan Year ending with or within the calendar year in which he attains age 70-1/2, in which case clause (2) shall not apply.

Except with respect to a 5-percent owner, a Participant's accrued benefit will be actuarially increased to take into account the period after age 70-1/2 in which the Participant does not receive any benefits under the plan. The actuarial increase will begin on April 1 following the calendar year in which the employee attains age 70-1/2 (January 1, 1997 in the case of an employee who attains age 70'/ prior to 1996), and will end on the date on which benefits commence after retirement in an amount sufficient to satisfy Code Section 401(a)(9). The amount of actuarial increase payable as of the end of the period for actuarial increases will be no less than the actuarial equivalent of the Participant's retirement benefits that would have been payable as of the date the actuarial increase must commence plus the actuarial equivalent of additional benefits accrued after that date, reduced by the actuarial equivalent of any distributions made after that date. The actuarial increase under this Section is not in addition to the actuarial increase required for that same period under Code Section 411 to reflect the delay in payments after normal retirement, except that the actuarial increase required under this Section will be provided even during the period during which an employee is in ERISA Section 203(a)(3)(B) service. For purposes of Code Section 411(b)(1)(H), the actuarial increase will be treated as an adjustment attributable to the delay in distribution of benefits after the attainment of normal retirement age. Accordingly, to the extent permitted under Code Section 411(b)(1)(H), the actuarial increase required under this Section will reduce the benefit accrual otherwise required under Code Section 411(b)(1)(H)(i), except that the rules on the suspension of benefits are not applicable.

(vii) Five Percent Owner. A Participant is treated as a five percent owner for purposes of this Section if the Participant is a five percent owner as defined in Code Section 416 at any time during the Plan Year ending with or within the calendar year in which such owner attains age 70 ½ . Once distributions have begun to a five percent owner under this Section, they must continue to be distributed, event if the Participant ceases to be a five percent owner in a subsequent year.

10.08 Purchase Of Nontransferable Annuity.

In general, the Trustee shall make payment of any pension directly to the Participant entitled to the payment. However, the Committee may instruct the Trustee to purchase a Nontransferable Annuity contract from an insurance company. A "Nontransferable Annuity" is an annuity which by its terms provides that it may not be sold, assigned, discounted, pledged as collateral for a loan or security for the performance of an obligation or for any other purpose, to any person other than the insurance company which issued it. If the Plan distributes an annuity contract, the contract must be a Nontransferable Annuity.

The Nontransferable Annuity contract must provide pension and other benefits in an amount not less than the pension and other benefits a Participant would receive under this Plan and otherwise must comply with the requirements of this Plan. In the event the Trustee purchases a Nontransferable Annuity contract for the benefit of a Participant, the Trustee may either assign the contract to the Participant or hold the contract for the benefit of the Participant pursuant to the instructions of the Committee. The Trustee also may purchase a Nontransferable Annuity contract for the benefit of a designated Beneficiary, surviving Spouse, or alternate payee under a qualified domestic relations order (as defined in Code Section 414(p)) entitled to distribution of all or a portion of the Participant's Vested Accrued Benefit.

10.09 Qualified Domestic Relations Order.

This Plan shall comply with the provisions of a qualified domestic relations order ("QDRO") (as defined in Code Section 414(p)). The Plan shall calculate the alternate payee's benefit pursuant to a QDRO as if the Participant had retired on the date on which such payment is to begin under such order (but taking into account only the present value of the benefits actually accrued and not taking into account the present value of any Employer subsidy for early retirement). If the Actuarial Equivalent of the alternate payee's benefits under the Plan is less than or equal to $5,000, the Trustee shall distribute such alternate payee's benefit in the form of a single lump sum as soon as administratively practicable after the qualified status of the QDRO has been confirmed. Effective on or after April 6, 2007, a domestic relations order that otherwise satisfies the requirement for a QDRO will not fail to be a QDRO: (1) solely because the order is issued after, or revises, another domestic relations order or QDRO; or (2) solely because of the time at which the order is issued, including issuance after the Benefit Commencement Date or after the Participant's death. A domestic relations order described in the foregoing sentence is subject to the same requirements and protections that apply to QDRO's. Distribution to an alternate payee under a QDRO shall not be made prior to the date the Participant has attained his "earliest retirement age" under the Plan as defined in Code Section 414(p). Nothing in this Section gives a Participant the right to receive a distribution at a time not permitted under the Plan, nor does this Section give the alternate payee the right to receive a form of payment not permitted under the Plan.

For purposes of this Article X, a former Spouse who is an alternate payee under a QDRO shall be treated as the Participant's Spouse or surviving Spouse to the extent provided under the QDRO. The survivor annuity requirements and the joint and survivor annuity requirements apply separately to the portion of the Participant's Vested Accrued Benefit subject to the QDRO and to the portion of the Participant's Vested Accrued Benefit not subject to such order.

Reasonable procedures shall be established to determine the qualified status of a domestic relations order. Upon receiving a domestic relations order, the Plan Administrator shall promptly notify the Participant and any alternate payee named in the order, in writing, of the receipt of the order and the Plan's procedures for determining the qualified status of the order. Within a reasonable period of time after receiving the domestic relations order, the Plan Administrator shall determine the qualified status of the order and notify the Participant and each alternate payee, in writing, of its determination. The notices required under this paragraph shall be provided by the Plan Administrator by mailing such notices to the individuals, at the addresses specified in the domestic relations order, or in a manner consistent with Department of Labor Regulations.

If any portion of the Participant's Vested Accrued Benefit is payable during the period the Plan Administrator is making its determination of the qualified status of the domestic relations order, the Plan Administrator shall make a separate accounting of the amounts payable. If the Plan Administrator determines the order is a QDRO within eighteen (18) months of the date any such amounts are first payable following receipt of the order, the Plan Administrator shall direct the Trustee to distribute the payable amounts in accordance with the order. If the Plan Administrator does not make its determination of the qualified status of the order within the 18-month determination period, the payable amounts shall be distributed in the manner the Plan would

distribute if the order did not exist and shall apply the order prospectively if it is later determined that the order is a QDRO.

10.10 Direct Rollovers.

(a) General Rule. Notwithstanding any provision of the Plan to the contrary that would otherwise limit a Distributee's election under this Section, a Distributee may elect, at the time and in the manner prescribed by the Plan Administrator, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover. The Plan Administrator may establish rules and procedures governing the processing of Direct Rollovers and limiting the amount or number of such Direct Rollovers in accordance with applicable Treasury Regulations. Distributions not transferred to an Eligible Retirement Plan in a Direct Rollover shall be subject to income tax withholding as provided under the Code and applicable state and local laws, if any.

(b) Definitions:

(i) "Eligible Rollover Distribution" – An Eligible Rollover Distribution is any distribution of all or any portion of the balance to the credit of the Distributee, except that an Eligible Rollover Distribution does not include: (i) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and the Distributee's designated Beneficiary, or for a specified period of ten years or more; (ii) any distribution to the extent such distribution is required under Code Section 401(a)(9); (iii) the portion of any distribution that is not includable in gross income (determined without regard to the exclusion for net unrealized appreciation with respect to employer securities); and (iv) any hardship distribution described in Code Section 401(k)(2)(B)(i)(IV) or Section 403(b)(11)(B).

(ii) "Eligible Retirement Plan" - An eligible retirement plan is an individual retirement account described in Code Section 408(a), an individual retirement annuity described in Code Section 408(b), an annuity plan described in Code Section 403(a), a qualified trust described in Code Section 401(a), a tax sheltered annuity plan described in Code Section 403(b) or an eligible deferred compensation plan described in Code Section 457(b) that is maintained by an eligible employer described in Code Section 457(e)(1)(A) that agrees to separately account for amounts transferred into such plan that accepts the distributee's eligible rollover distribution. The definition of eligible retirement plan shall also apply in the case of a distribution to the Employee's or former Employee's surviving Spouse or the Employee's or former Employee's Spouse or former Spouse who is the alternate payee under a qualified domestic relations order, as defined in Code Section 414(p). Effective May 1, 2007, the definition of "Eligible Retirement Plan" also shall apply in the case of a distribution to an individual retirement account described in Code Section 408(a) or individual retirement annuity described in Code Section 408(b) established for the purpose of receiving such distribution on behalf of a non-Spouse beneficiary of the Employee. For distributions made after December 31, 2007 to any Distributee (Participant or Beneficiary), an "Eligible Retirement Plan" shall include a Roth IRA described in Code Section 408A(b).

(iii) "Distributee" - A Distributee includes an Employee or former Employee. In addition, the Employee's or former Employee's surviving Spouse and the Employee's or former Employee's Spouse or former Spouse who is the alternate payee under a qualified domestic relations order, as defined in Code Section 414(p), are Distributees with regard to the interest of the Spouse or former Spouse. Effective May 1, 2007, the Employee's non-Spouse beneficiary also is a

Distributee, but only for distributions to individual retirement accounts described in Code Section 408(a) or individual retirement annuities described in Code Section 408(b), as provided in Section 10.10(b)(ii) of the Plan.

(iv) "Direct Rollover" - A Direct Rollover is a payment by the Plan to the Eligible Retirement Plan specified by the distributee.

(c) Special Rules Pertaining to Non-Spouse Beneficiary Rollover Right. For distributions on or after May 1, 2007, a non-Spouse beneficiary who is a "designated beneficiary" under Code Section 401(a)(9)(E) and the regulations thereunder, by a direct trustee-to-trustee transfer ("direct rollover"), may roll over all or any portion of his/her distribution to an individual retirement account/annuity the beneficiary establishes for purposes of receiving the distribution. In order to be able to roll over the distribution, the distribution otherwise must satisfy the definition of an eligible rollover distribution.

(i) Certain requirements not applicable. Although a non-Spouse beneficiary may roll over directly a distribution as provided in this Section 10.10, the distribution, if made prior to January 1, 2010, is not subject to the direct rollover requirements of Code Section 401(a)(31), the notice requirements of Code Section 402(f) or the mandatory withholding requirements of Code Section 3405(c). If a non-Spouse beneficiary receives a distribution from the Plan, the distribution is not eligible for a "60-day" rollover.

(ii) Trust Beneficiary. If the Participant's named beneficiary is a trust, the Plan may make a direct rollover to an individual retirement account/annuity on behalf of the trust, provided the trust satisfies the requirements to be a designated beneficiary within the meaning of Code Section 401(a)(9)(E).

(iii) Required Minimum Distributions Not Eligible for Rollover. A non-Spouse beneficiary may not roll over an amount which is a required minimum distribution, as determined under applicable Treasury regulations and other Internal Revenue Service guidance. If the Participant dies before his/her required beginning date and the non-Spouse beneficiary rolls over to an IRA the maximum amount eligible for rollover, the beneficiary may elect to use either the 5-year rule or the life expectancy rule, pursuant to Treas. Reg. Section 1.401(a)(9)-3, A-4(c), in determining the required minimum distributions from the IRA that receives the non-Spouse beneficiary's distribution.

10.11 True-Up Amounts. Except as otherwise provided in the Plan, any additional amounts the Plan Administrator determines a Participant to be entitled to after his benefit payments commence ("True-Up Amounts") shall be paid in a single sum as soon as administratively feasible after such determination is made and shall include appropriate adjustments, as determined by the Plan Administrator, for interest from the date the benefit payments commenced to the date payment of the True-Up Amounts is made. For purposes of this Section, interest shall be determined in accordance with Section 10.12(c).

10.12 Retroactive Annuity Starting Date.

(a) Notwithstanding anything contained in the Plan to the contrary, with respect to a Participant who receives the notices and explanations described in Sections 9.04 and 10.02, the Plan may provide a Participant's benefit based on his Retroactive Annuity Starting Date if the following requirements are satisfied:

(i) The Plan Administrator provides the written notices and explanations described in Sections 9.04 and 10.02 either:

(A) between 30 days and 180 days (90 days prior to January 1, 2007) before the date of the Participant's receipt of his first benefit payment based on his Retroactive Annuity Starting Date, or

(B) less than 30 days before the date of receipt of the Participant's first benefit payment based on his Retroactive Annuity Starting Date if the date of such payment is after the date such notices and explanations are provided to the Participant, the Participant affirmatively elects a form of distribution, and his Spouse consents, if necessary, pursuant to Section 10.02;

provided, however, that the Plan will not fail to satisfy the requirement of subparagraph (A) due solely to administrative delay that results in the commencement of benefits after the 180 days (90 days prior to January 1, 2007) described above;

(ii) The Participant affirmatively elects, at the time and in the manner specified by the Plan Administrator, to use the Retroactive Annuity Starting Date, and such election is made after the written notices and explanations described in paragraph (i) above are provided and on or before the date the Participant's first benefit payment is made;

(iii) The Participant's future periodic benefit payments based on the Retroactive Annuity Starting Date, if any, are the same as the periodic benefit payments that would have been paid to the Participant had payment actually commenced on the Retroactive Annuity Starting Date;

(iv) The Participant receives a make-up amount in a single sum, as determined by the Plan Administrator, to reflect any missed payment(s) due to the use of a Retroactive Annuity Starting Date (with appropriate adjustments, as determined by the Plan Administrator, for interest from the date the payments would have been made to the date benefit payments actually commence) as soon as administratively feasible after the make-up amount is determined;

(v) The Participant's Spouse, determined as of the date benefit payments actually commence, consents to the distribution of the make-up amount to the Participant in a manner that would satisfy the applicable consent requirements of Sections 9.04 and 10.02; provided, however, that this paragraph (v) shall not apply if the amount of the Spouse's survivor annuity payments under the Retroactive Annuity Starting Date election would be no less than the amount that the survivor payments to such Spouse would have been under a Qualified Joint and Survivor Annuity and that has an annuity starting date after the date that the notice and explanation described in subsection 9.04 was provided;

(vi) The benefit (including appropriate interest adjustments, as determined by the Plan Administrator) provided based on the Participant's Retroactive Annuity Starting Date would satisfy the requirements of Code Section 415 if the date the payments commence is substituted for the annuity starting date for all purposes, including for purposes of determining the applicable interest rate and mortality table; provided, however, that the requirement to apply Code Section 415 as of the date payments commence shall not apply in the case of a form of benefit that would have been excepted from the present value requirements of Treasury Regulation Section 1.417(e)-1(d)(6) if the distribution had actually commenced on the Retroactive Annuity Starting Date, if the date distribution commences is 12 months or less from the Retroactive Annuity Starting Date; and

(vii) In the case of a form of benefit that would have been subject to Code Section 417(e)(3) and Treasury Regulation Section 1.417(e)-1(d) if payments had commenced as of the Retroactive Annuity Starting Date, the distribution is no less than the benefit produced by applying the Applicable Interest Rate and Applicable Mortality Table (as described under Code Section 417(e)(3)) determined as of the date the payments commence to the annuity form that corresponds to the annuity form that was used to determine the benefit amount as of the Retroactive Annuity Starting Date.

(b) For purposes of this Section, "Retroactive Annuity Starting Date" means the date a Participant's annuity benefit should commence that is on or before the date the written explanations described in Sections 9.04 and 10.02 are provided to such Participant; provided, however, that such date shall not be earlier than the date upon which the Participant could have otherwise started receiving his benefit.

(c) For purposes of this Section, interest shall be determined using the interest rate applicable to a lump sum payment under Section 1.08 for the Plan Year in which the distribution of a make-up amount is made prorated for the period from the Retroactive Annuity Starting Date to the date benefit payments actually commence

ARTICLE XI

SUSPENSION OF BENEFITS UPON CERTAIN EMPLOYMENT OR REEMPLOYMENT

11.01 Suspension of Benefits. If a Participant continues to be employed by the Company or a Related Employer after his Normal Retirement Age, or is reemployed as an Eligible Employee after he has received or begun to receive a benefit under the Plan:

(a) no benefits shall be paid for any month before the Participant's Normal Retirement Age or for any month beginning on or after the Participant's Normal Retirement Age in which the Participant is credited with 40 or more Hours of Service;

(b) Department of Labor Regulation Section 2530.203-3, including the notice procedures referred to in Section 11.03, shall be followed for the periods of employment or reemployment described in subsection (a); and

(c) in the case of a Participant who continues to be employed after his Normal Retirement Age, benefits shall be determined pursuant to Section 7.02.

11.02 Benefits Upon Reemployment. Benefits upon the reemployment of an Employee shall be determined as set forth below.

(a) In General – Application of Next Gen Employee Provisions. Next Gen Employees are not considered Eligible Employees and shall not accrue any additional benefit under the Plan when reemployed by the Employer. While benefit payments (if applicable) to such a Next Gen Employee shall be suspended in accordance with Section 11.01, the automatic AB II Benefit conversion provisions that went into effect January 1, 2008 (as described below) shall not apply.

(b) Reemployments Occurring Prior to the Application of the Next Gen Employee Provisions. Effective January 1, 2008 and prior to the application of the Next Gen benefit structure, any reemployed Eligible Employee shall participate in the AB II Benefit pursuant to Article IV. The benefits payable upon a Participant's subsequent Termination of Service shall be determined as follows:

(i) Reemployment Before Commencing Benefits. If the Participant is reemployed before he has received or begun to receive a benefit under the Plan, his Credited Service and Point Service shall be restored if the Participant satisfies the requirements of Section 2.04(a). The value of the Participant's vested AB I Account or vested AB II Account, as applicable, upon reemployment is equal to the balance, if any, as of his Termination of Service, increased with Interest Credits for the period of absence. Notwithstanding the foregoing, effective January 1, 2008, any undistributed FAP Benefit or AB I Benefit shall be converted to an Opening Balance in accordance with the AB II provisions of Section 4.03(b).

(ii) Reemployment After Commencing Annuity Benefits. If the Participant is reemployed after he has begun to receive an annuity benefit under the Plan, his Credited Service and Point Service shall be restored, and his benefit after reemployment shall be determined as follows:

(A) On or after January 1, 2008 and prior to the application of the Next Gen benefit structure, if the Participant is a FAP Participant, the Participant's annuity benefits under the FAP Benefit shall be suspended pursuant to Section 11.01 and an Opening Balance shall be created in accordance with Section 4.03(b). For purposes of

calculating such Participant's Protected Benefit pursuant to Section 4.06(a), upon the Participant's subsequent Benefit Commencement Date, the Protected Benefit shall be reduced by the amount of the annuity benefits received by the Participant. Prior to January 1, 2008, a Participant's FAP Benefit was re-determined pursuant to Article VI upon the Participant's subsequent Termination of Service as if he then first retired, based on the Participant's Credited Service and Compensation before and after his absence.

(B) On or after January 1, 2008 and prior to the application of the Next Gen benefit structure, if the Participant is an AB I Participant or AB II Participant, upon reemployment, the Participant's annuity benefits under the AB I or the AB II Benefit shall be suspended pursuant to Section 11.01 and an Opening Balance shall be created in accordance with the AB II provisions of Section 4.03(b). For purposes of calculating such Participant's Protected Benefit pursuant to Section 4.06(b), if any, upon the Participant's subsequent Benefit Commencement Date, the Protected Benefit shall be reduced by the amount of the annuity benefits received by the Participant. Prior to January 1, 2008, an Opening Balance was calculated pursuant to Section 4.03(b) or 5.03(b), as applicable, based on the Single Life Annuity that was the Actuarial Equivalent of the annuity payment being made by the Plan. The Participant shall receive Pay-Based Credits pursuant to Section 4.04 or 5.04, based on the Participant's Point Service before and after the absence and his Compensation after the absence.

(C) The Participant shall be entitled during this period of reemployment (subject to the election procedures of Article X) to revise any prior election affecting the form in which benefits are paid, provided that the amount of any annuity benefit payable after his subsequent Termination of Service shall not be less than the amount payable in that form of payment as of his original Termination of Service.

(iii) Reemployment After Lump Sum Distribution. If the Participant is reemployed after receiving a lump sum distribution of his benefit under the Plan, his Credited Service and Point Service shall not be restored. However, the Plan shall consider all Vesting Service earned under the Plan. A Participant's benefit after reemployment shall be determined as follows:

(A) A FAP Participant shall become an AB II Participant with a $0 Opening Balance. Prior to January 1, 2008, if the Participant was a FAP Participant on or after reemployment, his FAP Benefit was based on the Participant's Credited Service after reemployment and his Compensation before and after the absence.

(B) An AB I Participant or an AB II Participant shall resume participation in the Plan as an AB II Participant with a $0 Opening Balance. The Participant shall receive Pay-Based Credits pursuant to 4.04 (or prior to January 1, 2008, if applicable, Section 5.04) based on the Participant's Point Service and Compensation after reemployment.

(C) Notwithstanding the foregoing, if a Participant is reemployed after receiving a lump sum distribution of his AB I Benefit or AB II Benefit but not his FAP Benefit, the undistributed Final Average Pay Benefit was converted to an Opening Balance in accordance with subsection (A).

11.03 Suspension of Benefits Notice. In the case of a Participant whose benefits are to be suspended after his Normal Retirement Age, the Plan Administrator shall notify him of the suspension by providing notice in accordance with Department of Labor Regulation Section 2530.203-3.

ARTICLE XII

CONTRIBUTIONS

12.01 Employer Contributions. The Employer shall make the contributions required to fund the cost of the benefits provided by this Plan. The Employer intends to make such contributions as are necessary to fund the Plan in accordance with the minimum funding standards of the Code. Contributions by the Employer are conditioned upon their deductibility under the Code for federal income tax purposes. Notwithstanding any provision in the Plan to the contrary, contributions and benefits shall be determined and paid in accordance with Code Section 436 and the provisions set forth in Schedule III which shall apply effective as of the date set forth in such Schedule.

12.02 Determination of Employer Contribution. The Employer, from its records and the reports of the actuary for the Plan, shall determine the amount of any contribution to be made by it to the Trust under the terms of the Plan. In this regard, the Employer may place full reliance upon all reports, opinions, tables, valuations, certificates and computations the actuary for the Plan furnishes the Employer.

12.03 Time of Payment of Employer Contribution. The Employer shall make its contribution to the Trustee within the time prescribed by the Code or applicable Treasury Regulations.

12.04 Return of Employer Contributions. Notwithstanding Section 21.01:

(a) In the case of a contribution made by the Employer by a mistake of fact, such contribution may be returned to the Employer within one year after its payment.

(b) All employer contributions to the Plan are conditioned on the allowance of their deductibility for federal income tax purposes under the Code. If the deduction of a contribution is disallowed by the Internal Revenue Service, to the extent of disallowance, the contribution may be returned to the Employer within one year after the disallowance.

(c) Any amounts returned under this Section shall be disposed of as directed by the Plan Administrator through uniform and nondiscriminatory rules. The Trustee shall not increase the amount of any contribution returnable under this Section for any earnings attributable to the contribution, but the Trustee shall decrease the Employer contribution returnable for any losses attributable to it.

12.05 Application of Forfeitures. The Trustee shall retain in the Trust all amounts representing the nonvested Accrued Benefit of Participants who have terminated employment. The Employer shall not use such benefits to increase the benefit of other Participants but instead shall use such amounts to reduce its contribution for future Plan Years.

12.06 Employee Contributions. The Plan does not permit nor require contributions from Participants.

ARTICLE XIII

LIMITATION ON BENEFITS

13.01 Effective Date. The limitations of this Article shall apply in Limitation Years beginning on or after July 1, 2007, except as otherwise provided herein.

13.02 Annual Benefit. The Annual Benefit otherwise payable to a Participant under the Plan at any time shall not exceed the Maximum Permissible Benefit. If the benefit the Participant would otherwise accrue in a Limitation Year would produce an Annual Benefit in excess of the Maximum Permissible Benefit, the benefit shall be limited (or the rate of accrual reduced) to a benefit that does not exceed the Maximum Permissible Benefit.

13.03 Other Defined Benefit Plans. If the Participant is, or has ever been, a Participant in another qualified defined benefit Plan (without regard to whether the Plan has been terminated) maintained by the Employer or a predecessor Employer, the sum of the Participant's Annual Benefits from all such Plans may not exceed the Maximum Permissible Benefit. Where the Participant's employer-provided benefits under all such defined benefit Plans (determined as of the same age) would exceed the Maximum Permissible Benefit applicable at that age, adjustment shall be made in the last plan in which the Participant actively participated prior to the determination of the Maximum Permissible Benefit.

13.04 Grandfather Provision. The application of the provisions of this Article shall not cause the Maximum Permissible Benefit for any Participant to be less than the Participant's accrued benefit under all the defined benefit plans of the Employer or a predecessor Employer as of the end of the last Limitation Year beginning before July 1, 2007 under provisions of the plans that were both adopted and in effect before April 5, 2007. The preceding sentence applies only if the provisions of such defined benefit Plans that were both adopted and in effect before April 5, 2007 satisfied the applicable requirements of statutory provisions, regulations, and other published guidance relating to Code Section 415 in effect as of the end of the last Limitation Year beginning before July 1, 2007, as described in Treasury Regulation Section 1.415(a)-1(g)(4).

13.05 Coordination with Other Rules. The limitations of this Article shall be determined and applied taking into account the rules in Section 13.07.

13.06 Definitions.

(a) Annual Benefit: A benefit that is payable annually in the form of a straight life annuity. Except as provided below, where a benefit is payable in a form other than a straight life annuity, the benefit shall be adjusted to an actuarially equivalent straight life annuity that begins at the same time as such other form of benefit and is payable on the first day of each month, before applying the limitations of this Article. For a Participant who has or will have distributions commencing at more than one annuity starting date, the Annual Benefit shall be determined as of each such annuity starting date (and shall satisfy the limitations of this Article as of each such date), actuarially adjusting for past and future distributions of benefits commencing at the other annuity starting dates. For this purpose, the determination of whether a new starting date has occurred shall be made without regard to Treasury Regulation Sections 1.401(a)-20, Q&A-10(d), and with regard to Treasury Regulation Sections 1.415(b)-1(b)(1)(iii)(B) and (C).

No actuarial adjustment to the benefit shall be made for (a) survivor benefits payable to a surviving Spouse under a qualified joint and survivor annuity to the extent such benefits would not be payable if the Participant's benefit were paid in another form; (b) benefits that are not directly related to retirement benefits (such as a qualified disability benefit, preretirement incidental death benefits, and

postretirement medical benefits); or (c) the inclusion in the form of benefit of an automatic benefit increase feature, provided the form of benefit is not subject to Code Section 417(e)(3) and would otherwise satisfy the limitations of this Article, and the Plan provides that the amount payable under the form of benefit in any Limitation Year shall not exceed the limits of this Article applicable at the annuity starting date, as increased in subsequent years pursuant to Code Section 415(d). For this purpose, an automatic benefit increase feature is included in a form of benefit if the form of benefit provides for automatic, periodic increases to the benefits paid in that form.

The determination of the Annual Benefit shall take into account social security supplements described in Code Section 411(a)(9) and benefits transferred from another defined benefit Plan, other than transfers of distributable benefits pursuant Treasury Regulation Section 1.411(d)-4, Q&A-3(c), but shall disregard benefits attributable to employee contributions or rollover contributions.

Effective for distributions in Plan years beginning after December 31, 2003, the determination of actuarial equivalence of forms of benefit other than a straight life annuity shall be made in accordance with Section 13.06(a)(i) or Section 13.06(a)(ii).

(i) Benefit Forms Not Subject to Code Section 417(e)(3): The straight life annuity that is actuarially equivalent to the Participant's form of benefit shall be determined under this Section 13.06(a)(i) if the form of the Participant's benefit is either (1) a nondecreasing annuity (other than a straight life annuity) payable for a period of not less than the life of the Participant (or, in the case of a qualified pre-retirement survivor annuity, the life of the surviving Spouse), or (2) an annuity that decreases during the life of the Participant merely because of (a) the death of the survivor annuitant (but only if the reduction is not below 50% of the benefit payable before the death of the survivor annuitant), or (b) the cessation or reduction of Social Security supplements or qualified disability payments (as defined in Code Section 401(a)(11)).

(A) Limitation Years beginning before July 1, 2007. For Limitation Years beginning before July 1, 2007, the actuarially equivalent straight life annuity is equal to the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit computed using whichever of the following produces the greater annual amount: (I) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form; and (II) a 5 percent interest rate assumption and the applicable mortality table defined in the Plan for that annuity starting date.

(B) Limitation Years beginning on or after July 1, 2007. For Limitation Years beginning on or after July 1, 2007, the actuarially equivalent straight life annuity is equal to the greater of (1) the annual amount of the straight life annuity (if any) payable to the Participant under the Plan commencing at the same annuity starting date as the Participant's form of benefit; and (2) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using a 5 percent interest rate assumption and the applicable mortality table defined in the Plan for that annuity starting date.

(ii) Benefit Forms Subject to Code Section 417(e)(3): The straight life annuity that is actuarially equivalent to the Participant's form of benefit shall be determined under this paragraph if the

form of the Participant's benefit is other than a benefit form described in Section 13.06(a)(i). In this case, the actuarially equivalent straight life annuity shall be determined as follows:

(A) Annuity Starting Date in Plan Years Beginning After 2005. If the annuity starting date of the Participant's form of benefit is in a Plan year beginning after 2005, the actuarially equivalent straight life annuity is equal to the greatest of (I) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form; (II) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using a 5.5 percent interest rate assumption and the applicable mortality table defined in the Plan; and (III) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using the applicable interest rate defined in the Plan and the applicable mortality table defined in the Plan, divided by 1.05.

(B) Annuity Starting Date in Plan Years Beginning in 2004 or 2005. If the annuity starting date of the Participant's form of benefit is in a Plan year beginning in 2004 or 2005, the actuarially equivalent straight life annuity is equal to the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using whichever of the following produces the greater annual amount: (I) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form; and (II) a 5.5 percent interest rate assumption and the applicable mortality table defined in the Plan.

(C) Transitional Rule. If the annuity starting date of the Participant's benefit is on or after the first day of the first Plan year beginning in 2004 and before December 31, 2004, the application of this Section 13.06(a)(ii)(C) shall not cause the amount payable under the Participant's form of benefit to be less than the benefit calculated under the Plan, taking into account the limitations of this Article, except that the actuarially equivalent straight life annuity is equal to the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using whichever of the following produces the greatest annual amount:

1. the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form;

2. the applicable interest rate defined in the Plan and the applicable mortality table defined in the Plan; and

3. the applicable interest rate defined in the Plan (as in effect on the last day of the last Plan year beginning before January 1, 2004, under provisions of the Plan then adopted and in effect) and the applicable mortality table defined in the Plan.

(b) Compensation: Compensation is defined as wages, within the meaning of Code Section 3401(a), and all other payments of compensation to an employee by the Employer (in the course of the Employer's

trade or business) for which the Employer is required to furnish the employee a written statement under Code Sections 6041(d), 6051(a)(3), and 6052 (commonly referred to as Form W-2 wages). Compensation shall be determined without regard to any rules under Code Section 3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Code Section 3401(a)(2)).

For any self-employed individual, Compensation shall mean earned income.

Except as provided herein, for Limitation Years beginning after December 31, 1991, compensation for a Limitation Year is the compensation actually paid or made available during such Limitation Year.

For Limitation Years beginning on or after July 1, 2007, compensation for a Limitation Year shall also include compensation paid by the later of 2-1/2 months after an employee's severance from employment with the Employer maintaining the Plan or the end of the Limitation Year that includes the date of the employee's severance from employment with the Employer maintaining the Plan, if:

(i) the payment is regular compensation for services during the employee's regular working hours, or compensation for services outside the employee's regular working hours (such as overtime or shift differential), commissions, bonuses, or other similar payments, and, absent a severance from employment, the payments would have been paid to the employee while the employee continued in employment with the Employer;

(ii) the payment is for unused accrued bona fide sick, vacation or other leave that the employee would have been able to use if employment had continued; or

(iii) the payment is received by the employee pursuant to a nonqualified unfunded deferred compensation Plan and would have been paid at the same time if employment had continued, but only to the extent includible in gross income.

Any payments not described above shall not be considered compensation if paid after severance from employment, even if they are paid by the later of 2-1/2 months after the date of severance from employment or the end of the Limitation Year that includes the date of severance from employment.

Back pay, within the meaning of Treasury Regulation Section 1.415(c)-2(g)(8), shall be treated as compensation for the Limitation Year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

For Limitation Years beginning after December 31, 1997, compensation paid or made available during such Limitation Year shall include amounts that would otherwise be included in Compensation but for an election under Code Sections 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b).

For Limitation Years beginning after December 31, 2000, Compensation shall also include any elective amounts that are not includible in the gross income of the employee by reason of Code Section 132(f)(4).

Compensation shall not include amounts paid as compensation to a nonresident alien, as defined in Code Section 7701(b)(1)(B), who is not a Participant in the Plan to the extent the compensation is excludable from gross income and is not effectively connected with the conduct of a trade or business within the United States.

(c) Defined Benefit Compensation Limitation: 100 percent of a Participant's High Three-Year Average Compensation, payable in the form of a straight life annuity.

In the case of a Participant who is rehired after a severance from employment, the Defined Benefit Compensation Limitation is the greater of 100 percent of the Participant's High Three-Year Average Compensation, as determined prior to the severance from employment, as adjusted pursuant to the preceding paragraph, if applicable; or 100 percent of the Participant's High Three-Year Average Compensation, as determined after the severance from employment under Section 13.06(g).

(d) Defined Benefit Dollar Limitation: Effective for Limitation Years ending after December 31, 2013, the Defined Benefit Dollar Limitation is $210,000, automatically adjusted under Code Section 415(d), effective January 1 of each year, as published in the Internal Revenue Bulletin, and payable in the form of a straight life annuity. The new limitation shall apply to Limitation Years ending with or within the calendar year of the date of the adjustment, but a Participant's benefits shall not reflect the adjusted limit prior to January 1 of that calendar year. In the case of a Participant who has had a severance from employment with the Employer, the Defined Benefit Dollar Limitation applicable to the Participant in any Limitation Year beginning after the date of severance shall be automatically adjusted under Code Section 415(d).

(e) Employer: For purposes of this Article, Employer shall mean the Employer that adopts this Plan, and all members of a controlled group of corporations, as defined in Code Section 414(b) (as modified by Section 415(h), all commonly controlled trades or businesses (as defined in Code Section 414(c), as modified, except in the case of a brother-sister group of trades or businesses under common control, by Code Section 415(h)), or affiliated service groups (as defined in Code Section 414(m)) of which the adopting Employer is a part, and any other entity required to be aggregated with the Employer pursuant to Code Section 414(o).

(f) Formerly Affiliated Plan of the Employer: A plan that, immediately prior to the cessation of affiliation, was actually maintained by the Employer and, immediately after the cessation of affiliation, is not actually maintained by the Employer. For this purpose, cessation of affiliation means the event that causes an entity to no longer be considered the Employer, such as the sale of a member controlled group of corporations, as defined in Code Section 414(b), as modified by Code Section 415(h), to an unrelated corporation, or that causes a plan to not actually be maintained by the Employer, such as transfer of plan sponsorship outside a controlled group.

(g) High Three-Year Average Compensation: The average compensation for the three consecutive years of service (or, if the Participant has less than three consecutive years of service, the Participant's longest consecutive period of service, including fractions of years, but not less than one year) with the Employer that produces the highest average. A year of service with the Employer is the calendar year. In the case of a Participant who is rehired by the Employer after a severance from employment, the Participant's high three-year average compensation shall be calculated by excluding all years for which the Participant performs no services for and receives no compensation from the Employer (the break period) and by treating the years immediately preceding and following the break period as consecutive. A Participant's compensation for a year of service shall not include compensation in excess of the limitation under Code Section 401(a)(17) that is in effect for the calendar year in which such year of service begins.

(h) Limitation Year: A Plan Year.

(i) Maximum Permissible Benefit: The lesser of the Defined Benefit Dollar Limitation or the Defined Benefit Compensation Limitation (both adjusted where required, as provided below).

(i) Adjustment for Less Than 10 Years of Participation or Service: If the Participant has less than 10 years of participation in the Plan, the Defined Benefit Dollar Limitation shall be multiplied by a fraction -- (i) the numerator of which is the number of Years (or part thereof, but not less than one year) of Participation in the Plan, and (ii) the denominator of which is 10. In the case of a Participant who has less than ten Years of Service with the Employer, the Defined Benefit Compensation Limitation shall be multiplied by a fraction -- (i) the numerator of which is the number of Years (or part thereof, but not less than one year) of Service with the Employer, and (ii) the denominator of which is 10.

(ii) Adjustment of Defined Benefit Dollar Limitation for Benefit Commencement Before Age 62 or after Age 65: Effective for benefits commencing in Limitation Years ending after December 31, 2001, the Defined Benefit Dollar Limitation shall be adjusted if the annuity starting date of the Participant's benefit is before age 62 or after age 65. If the annuity starting date is before age 62, the Defined Benefit Dollar Limitation shall be adjusted under Section 13.06(i)(ii)(A), as modified by Section 13.06(i)(ii)(C), If the annuity starting date is after age 65, the Defined Benefit Dollar Limitation shall be adjusted under Section 13.06(i)(ii)(B), as modified by Section 13.06(i)(ii)(C).

(A) Adjustment of Defined Benefit Dollar Limitation for Benefit Commencement Before Age 62:

1. Limitation Years Beginning Before July 1, 2007. If the annuity starting date for the Participant's benefit is prior to age 62 and occurs in a Limitation Year beginning before July 1, 2007, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) with actuarial equivalence computed using whichever of the following produces the smaller annual amount: (1) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan; or (2) a 5-percent interest rate assumption and the applicable mortality table as defined in the Plan.

2. Limitation Years Beginning on or After July 1, 2007.

a. Plan Does Not Have Immediately Commencing Straight Life Annuity Payable at Both Age 62 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is prior to age 62 and occurs in a Limitation Year beginning on or after July 1, 2007, and the Plan does not have an immediately commencing straight life annuity payable at both age 62 and the age of benefit commencement, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) with actuarial equivalence computed using a 5 percent interest rate assumption and the applicable mortality table for the annuity starting date as defined in the Plan (and expressing the Participant's age based on completed calendar months as of the annuity starting date).

b. Plan Has Immediately Commencing Straight Life Annuity Payable at Both Age 62 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is prior to age 62 and occurs in a Limitation Year beginning on or after July 1, 2007, and the Plan has an immediately commencing straight life annuity payable at both age 62 and the age of benefit commencement, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the lesser of the limitation determined under Section 13.06(i)(ii)(A)(2)(a) and the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i)) for years of participation less than 10, if required) multiplied by the ratio of the annual amount of the immediately commencing straight life annuity under the Plan at the Participant's annuity starting date to the annual amount of the immediately commencing straight life annuity under the Plan at age 62, both determined without applying the limitations of this Article.

(B) Adjustment of Defined Benefit Dollar Limitation for Benefit Commencement After Age 65:

1. Limitation Years Beginning Before July 1, 2007. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a Limitation Year beginning before July 1, 2007, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) with actuarial equivalence computed using whichever of the following produces the smaller annual amount: (1) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan; or (2) a 5-percent interest rate assumption and the applicable mortality table as defined in the Plan.

2. Limitation Years Beginning Before July 1, 2007.

a. Plan Does Not Have Immediately Commencing Straight Life Annuity Payable at Both Age 65 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a Limitation Year beginning on or after July 1, 2007, and the Plan does not have an immediately commencing straight life annuity payable at both age 65 and the age of benefit commencement, the Defined Benefit Dollar Limitation at the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required), with actuarial equivalence computed using a 5 percent interest rate assumption and the applicable mortality table for that annuity starting date as defined in the Plan (and expressing the Participant's age based on completed calendar months as of the annuity starting date).

b. Plan Has Immediately Commencing Straight Life Annuity Payable at Both Age 65 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a Limitation Year

beginning on or after July 1, 2007, and the Plan has an immediately commencing straight life annuity payable at both age 65 and the age of benefit commencement, the Defined Benefit Dollar Limitation at the Participant's annuity starting date is the lesser of the limitation determined under Section 13.06(i)(ii)(B)(2)(a) and the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) multiplied by the ratio of the annual amount of the adjusted immediately commencing straight life annuity under the Plan at the Participant's annuity starting date to the annual amount of the adjusted immediately commencing straight life annuity under the Plan at age 65, both determined without applying the limitations of this Article. For this purpose, the adjusted immediately commencing straight life annuity under the Plan at the Participant's annuity starting date is the annual amount of such annuity payable to the Participant, computed disregarding the Participant's accruals after age 65 but including actuarial adjustments even if those actuarial adjustments are used to offset accruals; and the adjusted immediately commencing straight life annuity under the Plan at age 65 is the annual amount of such annuity that would be payable under the Plan to a hypothetical Participant who is age 65 and has the same accrued benefit as the Participant.

(C) Notwithstanding the other requirements of this Section 13.06(i)(ii), no adjustment shall be made to the Defined Benefit Dollar Limitation to reflect the probability of a Participant's death between the annuity starting date and age 62, or between age 65 and the annuity starting date, as applicable, if benefits are not forfeited upon the death of the Participant prior to the annuity starting date. To the extent benefits are forfeited upon death before the annuity starting date, such an adjustment shall be made. For this purpose, no forfeiture shall be treated as occurring upon the Participant's death if the Plan does not charge Participants for providing a qualified preretirement survivor annuity, as defined in Code Section 417(c), upon the Participant's death.

(j) Minimum benefit permitted: Notwithstanding anything else in this Section to the contrary, the benefit otherwise accrued or payable to a Participant under this Plan shall be deemed not to exceed the Maximum Permissible Benefit if:

(i) the retirement benefits payable for a Limitation Year under any form of benefit with respect to such Participant under this Plan and under all other defined benefit Plans (without regard to whether a Plan has been terminated) ever maintained by the Employer do not exceed $10,000 multiplied by a fraction – (I) the numerator of which is the Participant's number of Years (or part thereof, but not less than one year) of Service (not to exceed 10) with the Employer, and (II) the denominator of which is 10; and

(ii) the Employer (or a predecessor Employer) has not at any time maintained a defined contribution plan in which the Participant participated (for this purpose, mandatory employee contributions under a defined benefit plan, individual medical accounts under Code Section 401(h), and accounts for postretirement medical benefits established under Code Section 419A(d)(1) are not considered a separate defined contribution plan).

(k) Predecessor Employer: If the Employer maintains a plan that provides a benefit which the Participant accrued while performing services for a former Employer, the former Employer is a predecessor Employer with respect to the Participant in the Plan. A former entity that antedates the Employer is

also a predecessor Employer with respect to a Participant if, under the facts and circumstances, the Employer constitutes a continuation of all or a portion of the trade or business of the former entity.

(l) Severance from Employment: An Employee has a severance from employment when the Employee ceases to be an employee of the Employer maintaining the Plan. An Employee does not have a severance from employment if, in connection with a change of employment, the employee's new Employer maintains the Plan with respect to the employee.

(m) Year of Participation: The Participant shall be credited with a Year of Participation (computed to fractional parts of a year) for each accrual computation period for which the following conditions are met: (1) the Participant is credited with at least the number of hours of service (or period of service if the elapsed time method is used) for benefit accrual purposes, required under the terms of the Plan in order to accrue a benefit for the accrual computation period, and (2) the Participant is included as a Participant under the eligibility provisions of the Plan for at least one day of the accrual computation period. If these two conditions are met, the portion of a year of participation credited to the Participant shall equal the amount of benefit accrual service credited to the Participant for such accrual computation period. A Participant who is permanently and totally disabled within the meaning of Code Section 415(c)(3)(C)(i) for an accrual computation period shall receive a Year of Participation with respect to that period. In addition, for a Participant to receive a Year of Participation (or part thereof) for an accrual computation period, the Plan must be established no later that the last day of such accrual computation period. In no event shall more than one Year of Participation be credited for any 12-month period.

(n) Year of Service: For purposes of Section 13.06(g), the Participant shall be credited with a Year of Service (computed to fractional parts of a year) for each accrual computation period for which the Participant is credited with at least the number of hours of service (or period of service if the elapsed time method is used) for benefit accrual purposes, required under the terms of the Plan in order to accrue a benefit for the accrual computation period, taking into account only service with the Employer or a predecessor Employer.

13.07 Other Rules.

(a) Benefits Under Terminated Plans. If a defined benefit Plan maintained by the Employer has terminated with sufficient assets for the payment of benefit liabilities of all Plan Participants and a Participant in the Plan has not yet commenced benefits under the Plan, the benefits provided pursuant to the annuities purchased to provide the Participant's benefits under the terminated Plan at each possible annuity starting date shall be taken into account in applying the limitations of this Article. If there are not sufficient assets for the payment of all Participants' benefit liabilities, the benefits taken into account shall be the benefits that are actually provided to the Participant under the terminated Plan.

(b) Benefits Transferred From the Plan. If a Participant's benefits under a defined benefit Plan maintained by the Employer are transferred to another defined benefit Plan maintained by the Employer and the transfer is not a transfer of distributable benefits pursuant to Treasury Regulation Section 1.411(d)-4, Q&A-3(c), the transferred benefits are not treated as being provided under the transferor Plan (but are taken into account as benefits provided under the transferee Plan). If a Participant's benefits under a defined benefit Plan maintained by the Employer are transferred to another defined benefit Plan that is not maintained by the Employer and the transfer is not a transfer of distributable benefits pursuant Treasury Regulation Section 1.411(d)-4, Q&A-3(c), the transferred benefits are treated by the Employer's Plan as if such benefits were provided under annuities purchased to provide benefits under a Plan maintained by the Employer that terminated immediately prior to the transfer with sufficient

assets to pay all Participants' benefit liabilities under the Plan. If a Participant's benefits under a defined benefit Plan maintained by the Employer are transferred to another defined benefit Plan in a transfer of distributable benefits pursuant Treasury Regulation Section 1.411(d)-4, Q&A-3(c), the amount transferred is treated as a benefit paid from the transferor Plan.

(c) Formerly Affiliated Plans of the Employer. A formerly affiliated plan of an Employer shall be treated as a plan maintained by the Employer, but the formerly affiliated plan shall be treated as if it had terminated immediately prior to the cessation of affiliation with sufficient assets to pay Participants' benefit liabilities under the Plan and had purchased annuities to provide benefits.

(d) Plans of a Predecessor Employer. If the Employer maintains a defined benefit Plan that provides benefits accrued by a Participant while performing services for a predecessor Employer, the Participant's benefits under a Plan maintained by the predecessor Employer shall be treated as provided under a Plan maintained by the Employer. However, for this purpose, the Plan of the predecessor Employer shall be treated as if it had terminated immediately prior to the event giving rise to the predecessor Employer relationship with sufficient assets to pay Participants' benefit liabilities under the Plan, and had purchased annuities to provide benefits; the Employer and the predecessor Employer shall be treated as if they were a single Employer immediately prior to such event and as unrelated Employers immediately after the event; and if the event giving rise to the predecessor relationship is a benefit transfer, the transferred benefits shall be excluded in determining the benefits provide under the Plan of the predecessor Employer.

(e) Special Rules. The limitations of this Article shall be determined and applied taking into account the rules in Treasury Regulation Sections 1.415(f)-1(d), (e), and (h).

(f) Aggregation with Multiemployer Plans.

(i) If the Employer maintains a multiemployer Plan, as defined in Code 414(f), and the multiemployer plan so provides, only the benefits under the multiemployer plan that are provided by the Employer shall be treated as benefits provided under a plan maintained by the Employer for purposes of this Article.

(ii) Effective for Limitation Years ending after December 31, 2001, a multiemployer plan shall be disregarded for purposes of applying the compensation limitation of Sections 13.06(c) and 13.06(i)(i) to a plan which is not a multiemployer plan.

ARTICLE XIV

EMPLOYER ADMINISTRATIVE PROVISIONS

14.01 Information To Plan Administrator. The Employer shall supply current information to the Plan Administrator as to the name, date of birth, date of employment, annual compensation, leaves of absence, Years of Service and date of termination of employment of each Employee who is, or who will be eligible to become, a Participant under the Plan, together with any other information which the Plan Administrator considers necessary. The Employer's records as to the current information the Employer furnishes to the Plan Administrator are conclusive as to all persons.

14.02 No Liability. The Employer assumes no obligation or responsibility to any of its Employees, Participants or Beneficiaries for any act of, or failure to act, on the part of the Committee or the Trustee.

14.03 Indemnity Of Committee. The Employer indemnifies and saves harmless the members of the Committee, and each of them, from and against any and all loss (including reasonable attorney's fees and costs of defense) resulting from liability to which the Committee, or the members of the Committee, may be subjected by reason of any act or conduct (except willful misconduct or gross negligence) in their official capacities in the administration of this Plan, the Trust, or both, including all expenses reasonably incurred in their defense, in case the Employer fails to provide such defense. The indemnification provisions of this Section shall not relieve any Committee member from any liability he may have under ERISA for breach of a fiduciary duty to the extent such indemnification is prohibited by ERISA. Furthermore the Committee members and the Employer may execute an agreement further delineating the indemnification agreement of this Section, provided the agreement must be consistent with and shall not violate ERISA.

ARTICLE XV

PARTICIPANT ADMINISTRATIVE PROVISIONS

15.01 Personal Data To Plan Administrator. Each Participant and each Beneficiary of a deceased Participant must furnish to the Plan Administrator such evidence, data or information as the Plan Administrator considers necessary or desirable for the purpose of administering the Plan. The provisions of this Plan are effective for the benefit of each Participant upon the condition precedent that each Participant will furnish promptly full, true and complete evidence, data and information when requested by the Plan Administrator, provided the Plan Administrator shall advise each Participant of the effect of his failure to comply with its request.

15.02 Address For Notification. Each Participant and each Beneficiary of a deceased Participant shall file with the Plan Administrator from time to time, in writing, his post office address and any change of post office address. Any communication, statement or notice addressed to a Participant, or Beneficiary, at his last post office address filed with the Plan Administrator, or as shown on the records of the Employer, shall bind the Participant, or Beneficiary, for all purposes of this Plan.

15.03 Notice Of Change In Terms. The Employer, within the time prescribed by ERISA and the applicable regulations, shall furnish all Participants and Beneficiaries a summary description of any material amendment to the Plan or notice of discontinuance of the Plan and all other information required by ERISA to be furnished without charge.

15.04 Assignment Or Alienation. Subject to Code Section 414(p) relating to qualified domestic relations orders, neither a Participant nor a Beneficiary shall anticipate, assign or alienate (either at law or in equity) any benefit provided under the Plan, and the Trustee shall not recognize any such anticipation, assignment or alienation. Furthermore, a benefit under the Plan is not subject to attachment, garnishment, levy, execution, or other legal or equitable process, including the claims of any trustee in bankruptcy or other representative of the Participant or Beneficiary in such action.

15.05 Litigation Against The Plan. If any legal action which is filed against the Trustee, the Plan Administrator, the Company as Plan sponsor, or the Committee, or against any member or members of the Committee, by or on behalf of any Participant or Beneficiary, results adversely to the Participant or to the Beneficiary, the Trustee shall reimburse itself, the Employer, the Company, or the Committee, or any member or members of the Committee, all costs and fees expended by it or them by surcharging all costs and fees against the sums payable under the Plan to the Participant or to the Beneficiary, but only to the extent a court of competent jurisdiction specifically authorizes and directs any such surcharges and only to the extent Code Section 401(a)(13) does not prohibit any such surcharges.

15.06 Information Available. Any Participant in the Plan or any Beneficiary may, during reasonable business hours, examine copies of the Plan description, latest annual report, any bargaining agreement, this Plan and Trust, and any contract or other instrument under which the Plan was established or is operated. The Employer shall maintain all of the items listed in this Section in its offices, or in such other place or places as it may designate from time to time in order to comply with the regulations issued under ERISA. Upon the written request of a Participant or Beneficiary, the Employer shall furnish him with a copy of any item listed in this Section. The Employer may make a reasonable charge to the requesting person for the copy so furnished.

15.07 Presenting Claims For Benefits. Any Participant or any other person claiming under a deceased Participant, such as a surviving Spouse or Beneficiary, may submit written application to the Plan Administrator for the payment of any benefit asserted to be due him under the Plan. Such application shall set forth the nature of the claim and such other information as the Plan Administrator may reasonably request. Promptly upon the receipt

of any application required by this Section, the Plan Administrator shall determine whether or not the Participant, Spouse, or Beneficiary involved is entitled to a benefit hereunder and, if so, the amount thereof and shall notify the claimant of its findings.

If a claim is wholly or partially denied, the Plan Administrator shall so notify the claimant within 90 days after receipt of the claim by the Plan Administrator, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the end of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render its final decision. Notice of the Plan Administrator's decision to deny a claim in whole or in part shall be set forth in a manner calculated to be understood by the claimant and shall contain the following:

(a) the specific reason or reasons for the denial;

(b) specific reference to the pertinent Plan provisions on which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(d) an explanation of the claims review procedure set forth in Section 15.08 hereof.

The Employer's notice of denial of benefits shall identify the name and address of the Committee member to whom the claimant may forward his appeal. If notice of denial is not furnished, and if the claim is not granted within the period of time set forth above, the claim shall be deemed denied for purposes of proceeding to the review stage described in Section 15.08.

15.08 Claims Review Procedure. If an application filed under Section 15.07 above shall result in a denial by the Plan Administrator of the benefit applied for, either in whole or in part, such applicant shall have the right, to be exercised by written application filed with the Committee within 60 days after receipt of notice of the denial of his application or, if no such notice has been given, within 60 days after the application is deemed denied under Section 15.07, to request the review of his application and of his entitlement to the benefit applied for. Such request for review may contain such additional information and comments as the applicant may wish to present. Within 60 days after receipt of any such request for review, the Committee shall reconsider the application for the benefit in light of such additional information and comments as the applicant may have presented, and if the applicant shall have so requested, shall afford the applicant or his designated representative a hearing before the Committee. The Committee shall also permit the applicant or his designated representative to review pertinent documents in its possession, including copies of the Plan document and information provided by the Employer relating to the applicant's entitlement to such benefit.

The Committee shall make a final determination with respect to the applicant's application for review as soon as practicable, and in any event not later than 60 days after receipt of the aforesaid request for review, except that under special circumstances, such as the necessity for holding a hearing, such 60-day period may be extended to the extent necessary, but in no event beyond the expiration of 120 days after receipt by the Committee of such request for review. If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the applicant prior to the commencement of the extension. Notwithstanding the foregoing, if the Committee's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Committee's final determination with respect to the applicant's application for review may be made within the period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii) in lieu of the 60-day period (120-day period if extended due to special circumstances) described above.

Notice of such final determination of the Committee shall be furnished to the applicant in writing, in a manner calculated to be understood by him, and shall set forth the specific reasons for the decision and specific references to the pertinent provisions of the Plan upon which the decision is based. If the decision on review is not furnished within the time period set forth above, the claim shall be deemed denied on review.

If such final determination is favorable to the applicant, it shall be binding and conclusive. If such final determination is adverse to such applicant, it shall be binding and conclusive unless the applicant notifies the Committee within 90 days after the mailing or delivery to him by the Committee of its determination that he intends to institute legal proceedings challenging the determination of the Committee, and actually institutes such legal proceeding within 180 days after such mailing or delivery.

15.09 Disputed Benefits. If any dispute shall arise between a Participant, or other person claiming under a Participant, and the Committee after the review of a claim for benefits, or in the event any dispute shall develop as to the person to whom the payment of any benefit under the Plan shall be made, the Trustee may withhold the payment of all or any part of the benefits payable hereunder to the Participant, or other person claiming under the Participant, until such dispute has been resolved by a court of competent jurisdiction or settled by the parties involved.

ARTICLE XVI

ADMINISTRATION

16.01 Allocation Of Responsibility Among Fiduciaries For Plan And Trust Administration. The fiduciaries shall have only those powers, duties, responsibilities and obligations as are specifically given to them under this Plan and the Trust. The Employers shall have the sole responsibility for making the contributions provided for under Article XII. The Committee shall have the sole authority to appoint and remove the Trustee and to amend or terminate, in whole or in part, the Plan or the Trust. The Committee shall have the final responsibility for the administration of the Plan, which responsibility is specifically described in this Plan and the Trust. The Committee shall be the "plan administrator" and the "named fiduciary" within the meaning of Title I of ERISA. In addition, the Committee shall have the specific delegated powers and duties described in the further provisions of this Article and such further powers and duties as specified in the Committee charter. The Trustee shall have the sole responsibility for the administration of the Trust and the management of the assets held under the Trust, all as specifically provided in the Trust.

Each fiduciary warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of this Plan and Trust, authorizing or providing for such direction, information, or action. Furthermore, each fiduciary may rely upon any such direction, information, or action of another fiduciary as being proper under this Plan and the Trust, and is not required under this Plan or the Trust to inquire into the propriety of any such direction, information, or action. It is intended under this Plan and the Trust that each fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and the Trust and shall not be responsible for any act or failure to act of another fiduciary. No fiduciary guarantees the Trust Fund in any manner against investment loss or depreciation in asset value.

16.02 Appointment Of Committee. The NiSource Benefits Committee (the "Committee") has administrative and investment responsibilities with respect to the Plan. In accordance with the Committee charter, the Chief Executive Officer of NiSource (the "CEO") has the authority to appoint and remove members of the Committee. All usual and reasonable expenses of the Committee may be paid in whole or in part by NiSource, and any expenses not paid by NiSource shall be paid by the Trustee out of the principal or income of the Trust Fund. Any members of the Committee who are Employees shall not receive compensation with respect to their services for the Committee.

16.03 Committee Procedures. The Committee may act at a meeting or in writing without a meeting, pursuant to the applicable Committee charter. The Committee may adopt such bylaws and regulations as it deems desirable for the conduct of its affairs. All decisions of the Committee shall be made by the vote of the majority, including actions in writing taken without a meeting. By appropriate action, the Committee may authorize one or more of its members to execute documents on its behalf, and the Trustee, upon written notification of such authorization, shall accept and rely upon such documents until notified in writing that such authorization has been revoked by the Committee.

16.04 Other Committee Powers And Duties. The Committee shall have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the discretionary authority to perform the following powers and duties:

(a) To construe and enforce the terms of the Plan and the rules and regulations it adopts, including the discretionary authority to interpret the Plan documents and documents related to the Plan's operation (including, but not limited to, issues of fact and questions of eligibility, benefits, status and rights of participants);

(b) To adopt rules of procedure and regulations necessary for the proper and efficient administration of the Plan, provided the rules are not inconsistent with the terms of the Plan and the Trust;

(c) To authorize and approve amendments to and restatements of the Plan;

(d) To direct the Trustee with respect to the crediting and distribution of the Trust;

(e) To review and render decisions respecting a claim for (or denial of a claim for) a benefit under the Plan, including judgment of the standard of proof required in any claim, subject to the requirements of applicable law and the Plan;

(f) To furnish the Employer with information which the Employer may require for tax or other purposes;

(g) To cause to be made all reports or other filing necessary to meet the reporting, disclosure and other filing requirements of the Code, ERISA and other applicable statutes, regulations and other authorities issued thereunder that are the responsibility of the Plan Administrator;

(h) To enlist or engage the services of employees of the Employer and other agents to assist it with the performance of any of its duties, as the Committee determines advisable;

(i) To engage the services of one or more "Investment Managers" (as defined in ERISA Section 3(38)), each of whom shall have full power and authority to manage, acquire or dispose (or direct the Trustee with respect to acquisition or disposition) of any Plan asset under its control;

(j) To establish and maintain a funding standard account and to make credits and charges to the account to the extent required by and in accordance with the provisions of the Code;

(k) To authorize any one of its members, or its secretary, to sign on its behalf any notices, directions, applications, certificates, consents, approvals, waivers, letters or other documents, such authority being evidenced by an instrument signed by all members and filed with the Trustee; and

(l) To make plan corrections permitted by the Employee Plans Compliance Resolution System ("EPCRS") issued by the Internal Revenue Service ("IRS"), as in effect from time to time, as follows: (i) to voluntarily correct any Plan qualification failure, including, but not limited to, failures involving Plan operation, impermissible discrimination in favor of Highly Compensated Employees, the specific terms of the Plan document, or demographic failures; (ii) implement any correction methodology permitted under EPCRS; and (iii) negotiate the terms of a compliance statement or a closing agreement proposed by the IRS with respect to correction of a Plan qualification failure.

16.05 Records And Reports. The Committee (or its delegate) shall exercise such authority and responsibility as it deems appropriate in order to comply with ERISA and regulations issued thereunder relating to records of Participants' Service, Accrued Benefit and the percentage of such Accrued Benefit that is Vested under the Plan; notifications to Participants; annual registration with the Internal Revenue Service; and annual reports to the Department of Labor.

16.06 Rules And Decisions. The Committee may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Committee shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Committee shall be entitled to rely upon information furnished by a Participant or Beneficiary, the Employer, the legal counsel of the Company, or the Trustee. Any determination by the Committee shall presumptively be conclusive and binding on all persons. The regularly kept records of the Company shall be conclusive and binding upon all persons with

respect to an Employee's date and length of employment, time and amount of Compensation and the manner of payment thereof, type and length of any absence from work, and all other matters contained therein relating to Employees.

16.07 Application And Forms For Benefits. The Committee may require a Participant or Beneficiary to complete and file with the Committee an application for a benefit and all other forms approved by the Committee, and to furnish all pertinent information requested by the Committee. The Committee may rely upon all such information so furnished it, including the Participant's or Beneficiary's current mailing address.

16.08 Authorization Of Benefit Payments. The Committee shall issue directions to the Trustee concerning all benefits that are to be paid from the Trust Fund pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with this Plan.

16.09 Funding Policy. The Committee shall review, not less often than annually, all pertinent Employee information and Plan data in order to establish the funding policy of the Plan and to determine the appropriate methods of carrying out the Plan's objectives. The Committee shall communicate periodically, as it deems appropriate, to the Trustee and to any Plan Investment Manager, the Plan's short-term and long-term financial needs so that investment policy can be coordinated with Plan financial requirements.

16.10 Unclaimed Accrued Benefit – Procedure. The Plan does not require the Employer, the Trustee or the Committee to search for, or ascertain the whereabouts of, any Participant or Beneficiary. It shall be the sole duty and responsibility of a Participant or Beneficiary to keep the Employer apprised of his whereabouts and of his most current mailing address. If any benefit to be paid under the Plan is unclaimed, within such time period as the Employer shall prescribe, it shall be forfeited and applied to reduce future costs. However, if the payee later files a claim for that benefit before his benefit has been escheated under applicable law and if that claim is approved, the forfeited benefit will be restored. If a forfeited benefit is restored, the Committee shall direct the Trustee to distribute the Participant's or Beneficiary's restored Accrued Benefit in accordance with Article VII as if the Participant's employment terminated in the Plan Year in which the Committee restores the forfeited Accrued Benefit.

16.11 Fiduciary Duties. In performing their duties, all fiduciaries with respect to the Plan shall act solely in the interest of the Participants and their Beneficiaries, and:

(a) For the exclusive purpose of providing benefits to the Participants and their Beneficiaries;

(b) With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims;

(c) To the extent a fiduciary possesses and exercises investment responsibilities, by diversifying the investments of the Trust so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(d) In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with the provisions of Title I of ERISA.

16.12 Allocation Or Delegation Of Duties And Responsibilities. In furtherance of their duties and responsibilities under the Plan, the Committee may, subject to the requirements of Section 16.11:

(a) Employ agents to carry out nonfiduciary responsibilities;

(b) Employ agents to carry out fiduciary responsibilities (other than trustee responsibilities as defined in ERISA Section 405(c)(3));

(c) Consult with counsel, who may be of counsel to the Employer or the Company; and

(d) Provide for the allocation of fiduciary responsibilities (other than trustee responsibilities as defined in ERISA Section 405(c)(3)) among the members of the Committee.

16.13 Procedure For The Allocation Or Delegation Of Fiduciary Duties.

Any action described in subsections (b) or (d) of Section 16.12 may be taken by the Committee only in accordance with the following procedure:

(a) Such action shall be taken by a majority of the Committee in a resolution approved by a majority of such Committee;

(b) The vote cast by each member of the Committee for or against the adoption of such resolution shall be recorded and made a part of the written record of the Committee's proceedings; and

(c) Any delegation of fiduciary responsibilities or any allocation of fiduciary responsibilities among members of the Committee may be modified or rescinded by the Committee according to the procedure set forth in subsections (a) and (b) of this Section 16.13.

16.14 Individual Statement. As determined in its discretion, the Plan Administrator shall, as soon as practicable and within the time prescribed by ERISA and the regulations under ERISA, deliver to such Participant (or Beneficiary of a deceased Participant) a statement reflecting the condition of his Accrued Benefit as of that date and such other information ERISA requires be furnished the Participant or Beneficiary upon request. No Participant, except a member of the Committee or its designated representative, shall have the right to inspect the records reflecting the Accrued Benefit of any other Participant.

16.15 Recovery of Overpaid Benefits. If a payment of benefits to a Participant, Beneficiary or other individual entitled to payment under the Plan (such as an alternate payee pursuant to Section 10.09) (collectively, the "Recipient") exceeds the amount provided for under the terms of the Plan, either by mistake or for any other reason, the Plan Administrator shall have the authority to seek reimbursement of such overpaid benefits from the Recipient (plus interest calculated in accordance with guidance set forth by the Internal Revenue Service). If a Recipient is receiving benefit payments at the time an overpayment of prior benefits is discovered, the Plan Administrator shall have the authority to reduce such Recipient's benefit payments going forward in an amount as necessary in the Plan Administrator's discretion to recover the overpaid benefits.

ARTICLE XVII

TRUST FUND

17.01 Establishment Of Trust. On behalf of the Plan, an agreement has been executed (the "Trust Agreement") to establish a trust to hold the assets of the Plan (the "Trust") and to appoint one or more persons or parties who shall serve as the Trustee. The Trustee so selected shall serve as the Trustee until otherwise replaced by the Committee or said Trust Agreement is terminated. The Committee may, from time to time, enter into such further agreements with the Trustee or other parties and make such amendments to said Trust Agreement as it may deem necessary or desirable to carry out this Plan. Any and all rights or benefits which may accrue to a person under this Plan shall be subject to all the terms and provisions of the Trust Agreement.

17.02 Investment Of Trust Assets. The Trustee shall have full discretion and authority with regard to the investment of the Trust, except with respect to a Plan asset under the control or direction of a properly appointed Investment Manager or with respect to a Plan asset subject to Committee direction of investment. The Committee shall have the right to direct the Trustee with respect to the investment and re-investment of Plan assets and to appoint one or more Investment Managers with control over some or all of such assets.

17.03 Fees And Expenses From Trust. The Trustee shall receive reasonable annual compensation as may be agreed upon from time to time between the Committee and the Trustee. The Trustee shall pay all expenses reasonably incurred by it or by the Employer, the Committee, or other professional advisers or administrators in the administration of the Plan from the Trust unless the Company or Related Employer pays the expenses. The Plan Administrator shall not treat any fee or expense paid, directly or indirectly, by the Company or a Related Employer as an Employer contribution.

17.04 Distribution Directions. If no one claims a payment or distribution made from the Trust, the Trustee shall promptly notify the Plan Administrator and shall dispose of the payment in accordance with the subsequent direction of the Plan Administrator.

17.05 Trust For Exclusive Benefit Of Participants Of The Plan And Their Beneficiaries. Except as otherwise provided herein, it shall be impossible under any circumstances at any time for any part of the corpus or income of the Trust to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their Beneficiaries.

ARTICLE XVIII

MEDICAL BENEFITS ACCOUNT

18.01 Purpose. The purpose of this Article XVIII is to set forth the medical, hospitalization, sickness, and related benefits (the "medical benefits") provided to certain retired Participants and their Spouses and dependents under the Plan in accordance with Code Section 401(h).

Benefits under this Article shall be provided by reimbursing participating Employers or other paying agents for the medical benefits provided to the eligible Participants, Spouses, and dependents identified in Section 18.02.

18.02 Eligibility for Medical Benefits. The persons eligible for the medical benefits provided by this Article are:

(a) each Participant who (1) is age 65 or older with eligibility for retirement benefits under the Plan; (2) is entitled to retiree medical benefits under one or more welfare benefit plans maintained by the Employer (the "medical plans"); and (3) is not a member of a collective bargaining unit at the time of retirement; and

(b) each eligible Spouse or dependent of such a retired Participant who is entitled to medical benefits under the medical plans as the Spouse or dependent of such Participant, but in no case including any person described in subsection (a) or any person employed by an Employer on a full-time basis.

Notwithstanding any other provisions of this Article, no medical benefits shall be provided hereunder on behalf of any retired Employee or a Spouse or dependent if the Employee was at any time a Key Employee (within the meaning of Section 19.03(a)). The medical benefits provided by this Article shall be identical to and in lieu of the medical benefits that otherwise would be provided to such Employees and their Spouses and dependents under the retiree medical plans maintained by the Employer.

The medical benefits provided under this Article XVIII and the Employer contributions made to fund such benefits shall not discriminate in favor of Highly Compensated Employees.

18.03 Right to Change Medical Benefits. Nothing in this Article shall be construed as guaranteeing to any retired or active Employee, Spouse, or dependent that any medical benefit shall continue to be provided under the medical plans for such persons in the future or under the same terms and conditions as such benefit has been provided under the medical plans. The Committee reserves the right to amend the medical plans at any time and for any reason, including the right to change the eligibility for coverage under such medical plans and the method by which the cost of the medical plans is shared by the Employer and Employees, Spouses, and dependents. Any amendments to the medical plans that would increase or decrease the benefits to which such individuals would be eligible shall be automatically incorporated herein by reference.

18.04 Funding and Subordination of Medical Benefits. Subject to the right reserved to the Committee to amend or terminate the benefits provided under this Article (which would result in the medical benefit obligations again becoming obligations of the medical plans, subject to the rights reserved to amend or terminate such plans), the Employer expects and intends to make actuarially determined contributions to a health benefits account under the Plan from time to time in accordance with Code Section 401(h).

The medical benefits provided hereunder shall be subordinate to the retirement benefits provided by the Plan. Medical benefits shall be deemed subordinate if the aggregate actual contributions for medical benefits, when added to the actual contributions for any life insurance protection under the Plan, do not exceed 25 percent of

the total actual contributions to the Plan (other than contributions to fund past service credits) after the date on which the separate account described in Section 18.05 was established. Further, other sources of funds, such as a VEBA trust, may be used to pay medical benefits provided hereunder before use of assets established in accordance with Code Section 401(h) and this Article.

18.05 Separate Account. A separate health benefits account shall be established and maintained under the Trust Fund out of which the Trustee shall provide medical benefits for retired Participants, Spouses, and dependents. Amounts contributed by the Employer to provide medical benefits shall be credited to such separate account. The separate account shall be maintained solely for record keeping purposes, and funds accounted for in the separate account may, but need not, be invested together with all other funds held by the Trustee under the Plan. At the time an Employer makes any contribution to the Plan, the Employer shall designate the portion of such contribution allocable to such separate account. In addition, the separate account shall be charged with any payment of medical benefits under this Section and any payment of expenses under Section 18.06.

Annual additions with respect to a Participant for a Plan Year shall not exceed $52,000 (or any higher amount permitted under Code Section 415(d)). For purposes of this section, "annual additions" mean the sum, credited to the Participant's separate health benefits account under the Plan and the Participant's accounts under all other qualified defined contribution plans maintained by the Company or a Related Employer, of:

(a) Company and Related Employer contributions;

(b) forfeitures; and

(c) Participant contributions.

Annual additions shall also include amounts allocated to any other individual medical account (as defined in Code Section 415(1)) that is part of a defined benefit plan maintained by the Company or a Related Employer and amounts attributable to post-retirement medical benefits allocated to the separate account of a key employee (as defined in Code Section 419A(d)(3)) under a welfare benefit fund (as defined in Code Section 419(e)) maintained by the Company or a Related Employer. Restored forfeitures, repaid distributions, rollover contributions, and loan payments shall not be treated as annual additions.

Effective as of the first Limitation Year beginning on or after July 1, 2007, restorative payments allocated to a Participant's Account, which include payments made to restore losses to the Plan resulting from actions (or a failure to act) by a fiduciary for which there is a reasonable risk of liability under Title I of ERISA or under other applicable federal or state law, where similarly situated participants are similarly treated do not give rise to an annual addition for any Limitation Year.

Effective as of the first Limitation Year beginning on or after July 1, 2007, if in any Plan Year a Participant's annual additions exceed the limit determined in this section, such excess shall be corrected by following the provisions of the defined contribution plan or plans in which the Participant is participating. Provided, however, that the correction method must be a method as set forth under the Employee Plans Compliance Resolution System, or any successor thereto. In the case of a Participant who does not receive annual additions under a defined contribution plan of the Company or a Related Employer, correction shall be made in accordance with a method set forth in the Employee Plans Compliance Resolution System, or any successor thereto.

18.06 Separate Account Assets.

(a) Trust assets allocated to the separate account for payment of medical benefits may not be used for, or diverted to, any other purpose (including payment of retirement benefits) prior to the satisfaction of all

liabilities of the Plan to provide for the payment of medical benefits. In this regard, if (1) the Plan is terminated, (2) this Article XVIII is terminated, or (3) one or more of the medical plans are terminated, the Plan shall only be responsible for medical benefits incurred prior to such termination. Any amounts remaining in the separate account after the satisfaction of all liabilities under this Article for medical benefits shall be returned to the Employer.

(b) Benefit payments made from the Trust Fund under this Article shall be limited to the amount attributed to the separate account established under Section 18.05. Upon depletion of the separate account, the Trust Fund will have no further obligation to provide retiree medical benefits.

18.07 Forfeitures. In the event the interest of any retired Participant or eligible Spouse or dependent in the separate account is forfeited prior to termination of the Plan or this Article, an amount equal to the amount of the forfeiture shall be applied as soon as possible to reduce future Employer contributions under this Article XVIII.

ARTICLE XIX

TOP HEAVY PROVISIONS

19.01 Minimum Benefit.

(a) Calculation Of Top Heavy Minimum Benefit.

If this Plan is Top Heavy in any Plan Year, the Plan guarantees a minimum benefit for each Non-Key Employee who is a Participant eligible for such benefit as provided by this Article XIX. A Participant's Top Heavy minimum benefit is an annual benefit, payable as a straight life annuity, equal to the Participant's Compensation multiplied by the applicable percentage. The applicable percentage is 2% multiplied by the number (not exceeding 10) of Years of Top Heavy Service as a Non-Key Employee Participant in the Plan. A "Year of Top Heavy Service" is a Plan Year in which the Plan is Top Heavy and the Participant completes a Year of Service. If a Non-Key Employee participates in this Plan and in a Top Heavy Defined Contribution Plan included in the Required Aggregation Group, the minimum benefits shall be provided under this Plan.

(b) Special Rules.

For purposes of determining the Top Heavy minimum benefit under paragraph (a), the Plan Administrator shall calculate a Participant's Compensation by averaging a Participant's annual Compensation over 5 consecutive Compensation periods (or, if less, the number of years of participation). When determining whether Compensation periods are consecutive for purposes of averaging Compensation, the Committee shall disregard Compensation periods for which the Participant does not complete at least 1,000 Hours of Service. A Participant under this Section shall include an Employee who is otherwise eligible to participate in the Plan, but who receives no accrual or a partial accrual because of the level of his Compensation, because he is not employed on the last day of the accrual computation period, or because the Plan is integrated with Social Security. If the accrual computation period does not coincide with the Plan Year, a minimum benefit accrues with respect to each accrual computation period falling wholly or partly in a Plan Year in which the Top Heavy minimum benefit requirement applies.

(c) No Reduction Of Minimum Benefit.

If a Participant accrues an additional benefit for a Plan Year by reason of this Section, the Participant's Accrued Benefit shall never be less than the Accrued Benefit determined at the end of that Plan Year, irrespective of whether the Plan is a Top Heavy plan for any subsequent Plan Year. The Employer shall not impute Social Security benefits to determine whether the Plan has satisfied the Top Heavy minimum benefit requirement for a Participant, nor shall the Plan offset a Participant's Social Security benefit from his Accrued Benefit attributable to the Top Heavy minimum benefit requirement.

19.02 Determination Of Top Heavy Status.

The Plan is "Top Heavy" for a Plan Year if the Top Heavy ratio as of the Determination Date exceeds 60%. The Top Heavy ratio is a fraction, the numerator of which is the sum of the Present Value of Accrued Benefits of all Key Employees as of the Determination Date, the contributions due as of the Determination Date, and distributions made within the five (5) Plan Year period ending on the Determination Date, and the denominator of which is a similar sum determined for all Employees. The Plan Administrator shall calculate the Top Heavy ratio without regard to the Accrued Benefit of any Non-Key Employee who was formerly a Key Employee. The Plan Administrator shall calculate the Top Heavy ratio by disregarding the Accrued Benefit (including distributions, if

any, of the Accrued Benefit) of an individual who has not received credit for at least one Hour of Service with the Employer during the one-year period ending on the Determination Date. In addition, the Plan Administrator shall disregard any part of any Accrued Benefit distributed by reason of Termination of Service, death or Disability in the one-year period ending on the Determination Date and, for all other events, the five-year period ending on the Determination Date. The Plan Administrator shall determine Present Value of Accrued Benefits as of the most recent valuation date for computing minimum funding costs falling within the twelve month period ending on the Determination Date, whether or not the Actuary performs a valuation that year, except as Code Section 416 and the Treasury Regulations require for the first and second Plan Year of the Plan. The Plan Administrator shall calculate the Top Heavy ratio, including the extent to which it must take into account distributions, rollovers, and transfers, in accordance with Code Section 416 and the Treasury Regulations thereunder.

If the Employer maintains other qualified plans (including a simplified employee pension plan), this Plan is Top Heavy only if it is part of the Required Aggregation Group, and the Top Heavy ratio for both the Required Aggregation Group and the Permissive Aggregation Group exceeds 60%. The Plan Administrator shall calculate the Top Heavy ratio in the same manner as required by the first paragraph of this Section, taking into account all plans within the Aggregation Group. To the extent the Plan Administrator must take into account distributions to a Participant, the Plan Administrator shall include distributions from a terminated plan that would have been part of the Required Aggregation Group if it were in existence on the Determination Date. The Plan Administrator shall calculate the Present Value of accrued benefits and the other amounts the Plan Administrator must take into account under qualified plans included within the group in accordance with the terms of those plans, Code Section 416 and the Treasury Regulations thereunder. If an aggregated plan does not have a valuation date coinciding with the Determination Date, the Plan Administrator shall value the accrued benefits or accounts in the aggregated plan as of the most recent valuation date falling within the twelve-month period ending on the Determination Date except as required by Code Section 416 and applicable Treasury Regulations. The Plan Administrator shall calculate the Top Heavy ratio with reference to the Determination Dates that fall within the same calendar year.

The accrued benefit of a Participant other than a Key Employee shall be determined under the method, if any, that uniformly applies for accrual purposes under all defined benefit plans maintained by the Employer; or if there is no such method, then as if such benefit accrued not more rapidly than the slowest accrual rate permitted under the fractional rule of Code Section 411(b)(1)(C).

For purposes of valuing Accrued Benefits under this Plan and accrued benefits under any other defined benefit plan taken into account in the Top Heavy ratio, the Plan Administrator shall use the actuarial assumptions of Section 1.08.

19.03 Definitions.

For purposes of this Article, the following definitions apply:

(a) "Key Employee" - As of any Determination Date, a Key Employee is a Participant who is a "key employee" under the provisions of Code Section 416(i) and the Treasury Regulations thereunder.

(b) "Non-Key Employees" - An Employee who does not meet the definition of Key Employee.

(c) "Compensation" - Compensation as defined in Code Section 415(c)(3) (but limited pursuant to Code Section 401(a)(17)).

(d) "Required Aggregation Group" - Required Aggregation Group means:

(i) Each qualified plan of the Employer in which at least one (1) Key Employee participates at any time during the 5 Plan Year period ending on the Determination Date; and

(ii) Any other qualified plan of the Employer that enables a plan described in (i) above to meet the requirements of Code Section 401(a)(4) or Code Section 410.

The Required Aggregation Group includes any Plan of the Employer which was maintained within the last 5 years ending on the Determination Date on which a top heaviness determination is being made if such plan would otherwise be part of the Required Aggregation Group for the Plan Year but for the fact it has been terminated.

(e) "Permissive Aggregation Group" - The Permissive Aggregation Group is the Required Aggregation Group plus any other qualified plans maintained by the Employer, but only if such group would satisfy in the aggregate the requirements of Code Section 401(a)(4) and Code Section 410. The Plan Administrator shall determine which plans to take into account in determining the Permissive Aggregation Group.

(f) "Employer" – The Company and any Related Employers. The Employer and the Plan Administrator shall not aggregate ownership interests in more than one Related Employer to determine whether an individual is a Key Employee because of his ownership interest in the Employer.

(g) "Determination Date" - For any Plan Year, the Determination Date is the Accounting Date of the preceding Plan Year or, in the case of the first Plan Year of the Plan, the Accounting Date of that Plan Year.

19.04 Application of Article. Notwithstanding any other provisions of the Plan to the contrary, for any Plan Year in which the Plan is "Top Heavy," the provisions of this Article shall apply, but only to the extent required by Code Section 416. In the event that Congress should provide by statute, or the Treasury Department should provide by regulation or ruling, that the limitations provided in this Article are no longer necessary for the Plan to meet the requirements of Code Section 401 or other applicable law then in effect, such limitations in this Article shall become void and shall no longer apply, without necessity of further amendment to the Plan.

As provided in Code Section 416, the payment of the minimum benefit set forth in Section 19.01 shall not apply with respect to any Employee included in a unit of Employees covered by a collective bargaining agreement between Employee representatives and an Employer if retirement benefits were the subject of good faith bargaining between the Employee representatives and the Employer.

ARTICLE XX

MISCELLANEOUS

20.01 Evidence. Anyone required to give evidence under the terms of the Plan may do so by certificate, affidavit, document or other information which the person to act in reliance may consider pertinent, reliable and genuine, and to have been signed, made or presented by the proper party or parties. The Committee and the Trustee shall be fully protected in acting and relying upon any evidence described under the immediately preceding sentence.

20.02 No Responsibility For Employer Action. Neither the Trustee nor the Committee shall have any obligation or responsibility with respect to any action required by the Employer, the Company, any Participant or eligible Employee, or for the failure of any of the above persons to act or make any payment or contribution, or to otherwise provide any benefit contemplated under this Plan, nor shall the Trustee or the Committee be required to collect any contribution required under the Plan, or to determine the correctness of the amount of any Employer contribution. Neither the Trustee nor the Committee need inquire into or be responsible for any action or failure to act on the part of the others, or on the part of any other person who has any responsibility regarding the management, administration or operation of the Plan, whether by the express terms of the Plan or by a separate agreement authorized by the Plan or by the applicable provisions of ERISA. Any action required of a corporate employer must be by its board of directors, an authorized committee thereof or by a duly authorized officer or other designate.

20.03 Fiduciaries Not Insurers. The Committee, the Plan Administrator, the Trustee, and the Employer in no way guarantee the Trust from loss or depreciation. The Employer does not guarantee the payment of any money which may be or becomes due to any person from the Trust. The liability of the Committee and the Trustee to make payment from the Trust at any time and all times is limited to the then available assets of the Trust.

20.04 Waiver Of Notice. Any person entitled to notice under the Plan may waive the notice, unless the Code or Treasury Regulations issued thereunder require the notice, or ERISA specifically or impliedly prohibits such a waiver.

20.05 Successors. The Plan shall be binding upon all persons entitled to benefits under it, their respective heirs and legal representatives, upon the Employer, its successors and assigns, and upon the Trustee, the Committee, the Plan Administrator and their successors.

20.06 Word Usage. Words used in the masculine also apply to the feminine or neuter where applicable, and wherever the context of the Plan dictates, the plural includes the singular and the singular includes the plural.

20.07 Headings. The headings of the Plan are for reference only. In the event of a conflict between a heading and the content of a Plan Section, the content of the Section of the Plan shall control.

20.08 Governing Law and Venue. In order to benefit Plan Participants by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 20.08 shall apply. Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana and of the United States for the Northern District of Indiana. The Company, each Related Employer that adopts the Plan, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such

parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

20.09 Employment Not Guaranteed. Nothing contained in this Plan, and nothing with respect to the establishment of the Trust, any modification or amendment to the Plan or Trust, the creation of any Accrued Benefit, or the payment of any benefit, shall give any Employee, Participant or any Beneficiary any right to continue employment, or any legal or equitable right against the Employer, an Employee of the Employer, the Plan Administrator, the Company, the Committee, the Trustee, or agents or employees of such individuals or entities. Nothing in the Plan shall be deemed or construed to impair or affect in any manner the right of the Employer, in its discretion, to hire Employees and, with or without cause, to discharge or terminate the service of Employees.

ARTICLE XXI

EXCLUSIVE BENEFIT; AMENDMENT; TERMINATION

21.01 Exclusive Benefit. Except as otherwise provided herein, the Employer shall have no beneficial interest in any asset of the Trust and no part of any asset in the Trust may ever revert to or be repaid to the Employer, either directly or indirectly; nor prior to the satisfaction of all liabilities with respect to the Participants and their Beneficiaries under the Plan, shall any part of the corpus or income of the Trust Fund, or any asset of the Trust, be (at any time) used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Beneficiaries.

21.02 Amendment To Plan or Trust. The Committee shall have the right at any time, and from time to time:

(a) To amend this agreement in any manner deemed necessary or advisable in order to qualify (or maintain qualification of) this Plan and the Trust under the appropriate provisions of the Code; and

(b) To amend the Plan and the Trust in any other manner.

No amendment shall authorize or permit any part of the Trust Fund (other than the part which is required to pay taxes and administration expenses) to be used for or diverted to purposes other than the exclusive benefit of the Participants or their Beneficiaries or estates. No amendment shall cause or permit any portion of the Trust Fund to revert to or become a property of the Employer.

Furthermore, an amendment (including any restatement of the Plan) may not decrease a Participant's Accrued Benefit, except to the extent permitted under Code Section 412(c)(8), and may not reduce or eliminate any benefits protected under Code Section 411(d)(6), determined immediately prior to the later of the adoption date or effective date of the amendment. In general, benefits protected under Code Section 411(d)(6) include early retirement benefits or retirement-type subsidies and optional forms of benefit payments.

The Committee shall make all amendments in writing. Each amendment shall state the date to which it is effective. Each amendment shall state the date to which it is either retroactively or prospectively effective, and may be executed by an authorized member or other delegate of the Committee.

21.03 Amendment To Vesting Provisions. The Committee reserves the right to amend the vesting provisions of the Plan at any time. However, the Committee shall not apply any such amended vesting schedule to reduce the Vested percentage of any Participant's Accrued Benefit derived from Employer contributions (determined as of the later of the date the Company adopts the amendment, or the date the amendment becomes effective) to a percentage less than the Vested percentage computed under the Plan without regard to the amendment. An amended vesting schedule shall apply to a Participant only if the Participant receives credit for at least one Hour of Service after the new schedule becomes effective.

If the Committee makes a permissible amendment to the vesting provisions of the Plan, each Participant having at least 3 Years of Vesting Service with the Employer may elect to have the percentage of his Vested Accrued Benefit computed under the Plan without regard to the amendment. The Participant must file his election with the Employer within 60 days of the latest of (a) the Committee's adoption of the amendment; (b) the effective date of the amendment; or (c) the Participant's receipt of a copy of the amendment. The Employer, as soon as practicable, shall forward to each affected Participant a true copy of any amendment to the vesting provisions, together with an explanation of the effect of the amendment, the appropriate form upon which the Participant may make an election to remain under the vesting provisions provided under the Plan prior to the amendment, and notice of the time within which the Participant must make an election to remain under the prior vesting provisions. The election

described in this Section does not apply to a Participant if the amended vesting provisions provide for vesting at least as rapid at all times as the vesting provisions in effect prior to the amendment. For purposes of this Section, an amendment to the vesting provisions of the Plan includes any Plan amendment which directly or indirectly affects the computation of the Vested percentage of an Employee's rights to his Employer derived Accrued Benefit.

21.04 Merger/Direct Transfers And Elective Transfers. The Committee shall not consent to, or be a party to, any merger or consolidation with another plan, or to a transfer of assets or liabilities to another plan, unless immediately after the merger, consolidation or transfer, the surviving plan provides each Participant a benefit equal to or greater than the benefit each Participant would have received had the Plan terminated immediately before the merger, consolidation or transfer. The Trustee possesses the specific authority to enter into merger agreements or agreements for the direct transfer of assets with the trustee of other retirement plans described in Code Section 401(a), and to accept the direct transfer of plan assets, or to transfer Plan assets as a party to any such agreement, upon the consent or direction of the Committee.

If permitted by the Committee in its discretion, the Trustee may accept a direct transfer of plan assets on behalf of an Employee prior to the date the Employee becomes a Participant in the Plan. If the Trustee accepts such a direct transfer of plan assets, the Committee and Trustee shall treat the Employee as a Participant for all purposes of the Plan, except the Employee shall not accrue benefits until he actually becomes a Participant in the Plan.

Unless a transfer of assets to this Plan is an Elective Transfer, the Plan will preserve all Code Section 411(d)(6) protected benefits with respect to the transferred assets, in the manner described in Section 21.02. A transfer is an "Elective Transfer" if: (a) the transfer satisfies the first paragraph of this Section; (b) the transfer is voluntary, under a fully informed election by the Participant; (c) the Participant has an alternative that retains his Code Section 411(d)(6) protected benefits (including an option to leave his benefit in the transferor plan, if that plan is not terminating); (d) the transfer satisfies the applicable spousal consent requirements of the Code; (e) the transferor plan satisfies the joint and survivor notice requirements of the Code, if the Participant's transferred benefit is subject to those requirements; (f) the Participant has a right to immediate distribution from the transferor plan, in lieu of the Elective Transfer; (g) the transferred benefit is at least the greater of the single sum distribution provided by the transferor plan for which the Participant is eligible or the present value of the Participant's accrued benefit under the transferor plan payable at that plan's normal retirement age; (h) the Participant has a one hundred percent (100%) Vested interest in the transferred benefit; and (i) the transfer otherwise satisfies applicable Treasury Regulations. If this Plan accepts an Elective Transfer from a defined contribution plan, the Plan guarantees a benefit derived from that Elective Transfer equal to the value of the transferred amount, expressed as an annual benefit payable at Normal Retirement Age in the normal form of benefit described in Section 7.01 of the Plan. The Trustee shall distribute this guaranteed benefit attributable to the Elective Transfer at the same time and in the same manner as it distributes the Participant's Accrued Benefit, and the Committee shall treat the guaranteed benefit as part of the Participant's Accrued Benefit for purposes of valuing the Participant's Accrued Benefit under any consent or election requirements provided in the Plan. An Elective Transfer may occur between qualified plans of any type.

The Trustee shall hold, administer and distribute any transferred assets as a part of the Trust Fund, and the Trustee shall maintain a separate Transfer Account for the benefit of the Employee on whose behalf the Trustee accepted the transfer in order to reflect the value of the transferred assets.

Furthermore, a merger or direct transfer described in this Section of the Plan is not a termination for purposes of the special distribution provisions described in this Section.

21.05 Discontinuance. The Committee shall have the right, at any time, to suspend or discontinue the contributions of any Employer under the Plan, and to terminate, at any time, this Plan and the Trust. With respect to any specific Employer, the Plan shall terminate upon the first to occur of the following:

(a) The date terminated by action of the Committee.

(b) The date the Employers shall be judicially declared bankrupt or insolvent.

(c) The dissolution, merger, consolidation or reorganization of the Employer, or the sale by the Employer of all or substantially all of its assets, unless the successor or purchaser makes provision to continue the Plan, in which event the successor or purchaser must substitute itself as the Employer under this Plan.

21.06 Full Vesting On Termination. Notwithstanding any other provision of the Plan to the contrary, upon either full or partial termination of the Plan, an affected Participant's right to his Accrued Benefit shall be 100% Vested.

21.07 Partial Termination. Upon termination of the Plan with respect to a group of Participants which constitutes a partial termination of the Plan, the Trustee shall allocate and segregate for the benefit of the Employees then or theretofore employed by the Employer with respect to which the Plan is being terminated the proportionate interest of such Participants in the Trust Fund. Such proportionate interest shall be determined by the actuary for the Plan. The actuary shall make this determination on the basis of the contributions made by the Employer, the provisions of this Article and such other considerations as the actuary deems appropriate. The fiduciaries shall have no responsibility with respect to the determination of any such proportionate interest.

The funds so allocated and segregated shall be used by the Trustee to pay benefits to or on behalf of Participants in accordance with Section 21.09.

21.08 Termination. Upon termination of the Plan, the distribution provisions of the Plan shall remain operative, except that: (i) if the present value of the Participant's Vested Accrued Benefit does not exceed $5,000, the Committee shall direct the Trustee to distribute the Participant's Vested Accrued Benefit to him in a lump sum as soon as administratively practicable after the Plan terminates; and (ii) if the present value of the Participant's Vested Accrued Benefit exceeds $5,000, the Participant or the Beneficiary may, in addition to the distribution events permitted under the Plan, elect to have the Trustee commence distribution of his Vested Accrued Benefit (in accordance with Article VII, VIII or IX) as soon as administratively practicable after the Plan terminates.

To liquidate the Trust, the Committee may purchase an immediate or deferred annuity contract for each Participant which protects the Participant's distribution rights under the Plan, if the present value of the Participant's Vested Accrued Benefit exceeds $5,000.

The Trust shall continue until the Trustee, after written direction from the Committee, has distributed all of the benefits under the Plan. A resolution or amendment to freeze all future benefit accruals but otherwise to continue maintenance of this Plan is not a termination for purposes of this Section. Furthermore, a merger or direct transfer described in Section 21.04 of the Plan is not a termination for purposes of the special distribution provisions described in this Section

21.09 Distribution Upon Termination Of Trust Fund. Upon termination of the Plan in whole or in part, or upon termination of employment of a group of Participants constituting a partial termination of the Plan, each such Participant's Accrued Benefit based on his service, Credited Service and Compensation prior to the date of termination (and considering the Interest Crediting Rate set forth in Section 4.05(d) and 5.05(d)) shall become fully vested and Vested to the extent funded. In no event shall any Participant or Beneficiary have recourse to other than the Plan Trust, or if applicable, the Pension Benefit Guaranty Corporation.

In the case of a complete termination of the Plan, the assets then held in the Trust shall be allocated, after payment of all expenses of administration or liquidation, in the manner prescribed by ERISA Section 4044.

21.10 Manner Of Distribution. Subject to the foregoing provisions of this Article XXI, distributions may be implemented through the continuance of the Trust, the creation of a new trust, the purchase of Nontransferable Annuity Contracts, distributions in cash, in securities or other assets in kind (based on their fair market value as of the date of distribution), or a combination thereof, subject to the requirements of the Pension Benefit Guaranty Corporation and as the Committee in its discretion shall determine.

21.11 Overfunding. If there are assets remaining after satisfying all liabilities to Participants and Beneficiaries upon termination of the Plan, the Trustee shall return the amount by which the Employer has overfunded the Plan to the Employer. The Employer shall instruct the Trustee regarding the amount of overfunding to be so returned.

21.12 Special Restriction On Benefit. In the event of Plan termination, the benefit of any Highly Compensated Employee (active or former) is limited to a benefit that is nondiscriminatory under Code Section 401(a)(4).

Benefits distributed to any of the twenty-five (25) most highly compensated active and former Highly Compensated Employees are restricted such that the annual payments are no greater than an amount equal to the payment that would be made on behalf of the Employee under a Single Life Annuity that is the Actuarial Equivalent of the sum of the Employee's Accrued Benefit and the Employee's other benefits under the Plan.

The preceding paragraph shall not apply if: (a) after payment of the benefit to an Employee described in the preceding paragraph, the value of Plan assets equals or exceeds one hundred ten percent (110%) of the value of current liabilities, as defined in Code Section 412(l)(7); or (b) the value of the benefits for an Employee described above is less than one percent (1%) of the value of current liabilities.

For purposes of this section, "benefit" includes loans in excess of the amount set forth in Code Section 72(p)(2)(A), any periodic income, any withdrawal values payable to a living Employee, and any death benefits not provided for by insurance on the Employee's life.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

IN WITNESS WHEREOF, this Amendment and Restatement of the Columbia Energy Group Pension Plan is hereby executed on this 23rd day of December, 2014, by the duly authorized representative of the NiSource Benefits Committee, to be effective as of January 1, 2014.

NISOURCE BENEFITS COMMITTEE

By: _____

Its: _____

Schedule I
List of Participating Employers

PARTICIPATING EMPLOYERS IN THE COLUMBIA ENERGY GROUP PENSION PLAN

Name of Participating Employer

1. Columbia Energy Group
2. CNS Microwave
3. Columbia Gas of Kentucky
4. Columbia Gas of Maryland
5. Columbia Gas of Ohio
6. Columbia Gas of Pennsylvania
7. Columbia Gas of Virginia
8. Columbia Gas Transmission Corp
9. Columbia Gulf Transmission Co
10. Columbia Deep Water Services Company

Schedule II
Cash Balance Election Periods

This Schedule II sets forth the cash balance election periods offered under the Plan, as previously described in the Plan 2006 Restatement or as may be subsequently modified to reflect additional election periods offered under the Plan as determined by the Committee.

1. 2000 Choice Period -- Election of AB I Benefit. Except as otherwise provided below, each Participant who was an Eligible Employee as of December 31, 1999 was entitled to elect to have his accruals after that date determined under the AB I Benefit provisions of Article V. Any such election must have been made no later than April 30, 2000, became irrevocable as of that date, and was effective as of January 1, 2000. The Participant made this election by giving notice at a time and in a manner specified by the Plan Administrator. If a Participant failed to make an election, the Participant's benefits shall be determined under the FAP Benefit provisions, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan.

   Notwithstanding the foregoing, a Participant was not entitled to make this election if he:

   (a) was a Union Employee and the collective bargaining agreement covering the Employee did not provide for participation in the AB I Benefit as of January 1, 2000;

   (b) was receiving required minimum distributions pursuant to Section 10.07 as of January 1, 2000;

   (c) was on a Disability leave or receiving pay continuation benefits as of January 1, 2000;

   (d) elected to retire early under the Voluntary Incentive Retirement Program offered to TCO employees pursuant to Appendix A; or

   (e) was on an unpaid leave of absence as of January 1, 2000.

   If a Participant who has attained Normal Retirement Age or Early Retirement Age elects to commence or receive benefits as of a Benefit Commencement Date that occurs prior to the end of the foregoing election period, the Participant's benefits shall be determined under the AB I Benefit provisions or the FAP Benefit provisions, whichever produces the larger benefit, without regard to any election that the Participant makes pursuant to this subsection.

   For purposes of calculating benefits under the 2000 Choice Period, the Conversion Date for purposes of determining the Opening Balance, Pay-Based Credits and Interest Credits is January 1, 2000. The Conversion Date for purposes of calculating the Protected Benefit is April 30, 2000 (or Termination of Service, if earlier) (and considering Compensation as of December 31, 1999).

2. 2004 Choice Period -- Election of AB I Benefit. Except as otherwise provided below, and pursuant to changes in collective bargaining agreements (subsequent to the foregoing 2000 Choice period) that provide for participation in the AB I Benefit for covered Employees, each Participant in the Plan as of December 31, 2003 accruing a FAP Benefit who was still such a Participant as of May 31, 2004, and who was not eligible to make an election under subsection (1) above, was entitled to elect to have his accruals on and after January 1, 2004 determined under the AB I Benefit provisions of Article V. Any such election must have been made no later than May 31, 2004, became irrevocable as of that date, and was effective as of January 1, 2004. The Participant made this election by giving notice at a time and in a

manner specified by the Plan Administrator. If a Participant failed to make an election, the Participant's benefits shall be determined under the FAP Benefit provisions, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan. Notwithstanding the foregoing, a Participant was not entitled to make this election if he:

(a) was receiving required minimum distributions pursuant to Section 10.07 as of January 1, 2004;

(b) was on a Disability leave or receiving pay continuation benefits as of January 1, 2004; or

(c) was on an unpaid leave of absence as of January 1, 2004.

If a Participant who has attained Normal Retirement Age or Early Retirement Age elects to commence or receive benefits as of a Benefit Commencement Date that occurs prior to the end of the foregoing election period, the Participant's benefits shall be determined under the AB I Benefit provisions or the FAP Benefit provisions, whichever produces the larger benefit, without regard to any election that the Participant makes pursuant to this subsection.

For purposes of calculating benefits under the 2004 Choice Period, the Conversion Date for purposes of determining the Opening Balance, Pay-Based Credits and Interest Credits is January 1, 2004. The Conversion Date for purposes of calculating the Protected Benefit is May 31, 2004 (or Termination of Service, if earlier) (and considering Compensation as of December 31, 2003).

3. 2006 Choice Period -- Election of AB II Benefit. Except as otherwise provided below, each Exempt Employee participating in the Plan as of October 1, 2005 who was participating as of January 1, 2006, including any Exempt Employee receiving benefits under a short term disability plan maintained by an Employer, was entitled to elect to have his accruals on and after January 1, 2006 determined under the AB II Benefit provisions of Article IV. Any such election must have been made no later than December 14, 2005, became irrevocable as of that date, and was effective as of January 1, 2006. The Exempt Employee made this election by giving notice at a time and in a manner specified by the Plan Administrator. If an Exempt Employee failed to make a timely election, the Exempt Employee's benefits shall be determined under the FAP Benefit provisions or AB I Benefit provisions, as applicable, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan.

Notwithstanding the foregoing, an Exempt Employee was not entitled to make this election, and, therefore, shall remain a Participant in the benefit option under which he is currently participating, if he:

(a) was a Union Employee and the collective bargaining agreement covering the Employee does not provide for participation in the AB II Benefit provisions as of January 1, 2006;

(b) was a Non-Exempt Employee;

(c) was receiving required minimum distributions pursuant to Section 10.07 as of January 1, 2006;

(d) was on a Disability leave or receiving pay continuation benefits as of January 1, 2006;

(e) elected to retire early under the Voluntary Incentive Retirement Program offered to TCO employees pursuant to Appendix A; or

(f) was on an unpaid leave of absence as of January 1, 2006.

For purposes of calculating benefits under the 2006 Choice Period, the Conversion Date for purposes of determining the Opening Balance, Pay-Based Credits and Interest Credits is January 1, 2006. The Conversion Date for purposes of calculating the Protected Benefit is December 31, 2005 (or Termination of Service, if earlier).

4. Election After a Disability. Effective January 1, 2009, a Participant returning to active employment after a Disability shall be governed by the provisions of Section 3.04(d). Prior to January 1, 2009, a Participant returning to active employment after a Disability shall be subject to the cash balance election provisions set forth below.

   (a) Disability During or After 2000 Choice Period. If a Participant was on a Disability leave as of January 1, 2000, as described in subsection (1)(c), and returned to work as an Eligible Employee (other than a Union Employee where the applicable collective bargaining agreement did not provide for participation in the AB I Benefit), the Participant was entitled to elect to have his future accruals determined under AB I Benefit provisions. Any such Participant made this election within 45 days after the Participant's return to work as an Eligible Employee.

   (b) Disability During or After 2004 Choice Period. If a Participant was on a Disability leave as of January 1, 2004, as described in subsection (2)(b), and returned to work as an Eligible Employee (other than a Union Employee where the applicable collective bargaining agreement did not provide for participation in the AB I Benefit), the Participant was entitled to elect to have his future accruals determined under AB I Benefit provisions. Any such Participant made this election within 45 days after the Participant's return to work as an Eligible Employee.

   (c) Disability Under the AB II Benefit Provisions. If a Participant was on a Disability leave as of January 1, 2006, as described in subsection (3)(d), and returned to work as an Eligible Employee to whom the AB II provisions otherwise apply, the Participant was entitled to elect to have his future accruals determined under AB II Benefit provisions. Any such election must have been made no later than 90 days after such Participant returned to active employment with an Employer.

   Any election pursuant to this subsection (4) became irrevocable as of the end of the applicable election period and was effective as of the date of return to active employment. The Participant made this election by giving notice in a manner specified by the Plan Administrator. If a Participant failed to make a timely election, the Participant's benefits shall be determined under the benefit provisions applicable during the period of Disability. For purposes of elections under this subsection (4), the Conversion Date was the first day of the month coincident with or next following the date of return to active employment, unless otherwise provided as set forth in the Plan 2006 Restatement.

5. Change in Status Election Periods. Effective January 1, 2009, a Participant experiencing a change in employment status due to a transfer shall be governed by the provisions of Section 3.04. Similarly, effective January 1, 2008, a Participant returning to active employment after a Termination of Service shall be governed by the provisions of Section 11.02. Prior to such dates, certain cash balance election provisions applied upon a change in employment status as set forth in the Plan 2006 Restatement. Accordingly, by way of example, but not limited hereto, the following election periods applied.

   (a) Union Employees – AB I Elections. A Participant (to whom the AB I provisions otherwise applied) was entitled to elect to have benefits accrue under the AB I Benefit provisions if the Participant was a

Union Employee as of January 1, 2000, but whose collective bargaining agreement did not provide for participation in the AB I Benefit as of such date, and one of the following conditions occurred:

(i) the collective bargaining agreement subsequently provided for participation in the AB I Benefit for covered employees;

(ii) the Participant became an Eligible Employee other than a Union Employee; or

(iii) the Participant became a Union Employee where the applicable collective bargaining agreement provided for participation in the AB I Benefit.

Any such Participant made this election within 45 days after the Plan Administrator received notice of one of the foregoing events in a manner similar to the election period described in subsection (4) above.

(b) Non-Exempt to Exempt Transfers – AB II Elections. Any former Non-Exempt Employee who transferred employment to become an Exempt Employee between October 1, 2005 and December 31, 2008, was entitled to elect to have his future accruals determined under AB II Benefit provisions pursuant to a 90-day election period in a manner similar to the election period described in subsection (4) above.

Schedule III
Benefit Restrictions Pursuant to Code Section 436

This Schedule III sets forth the provisions relating to benefit restrictions that shall apply under Code Section 436 (as added by the Pension Protection Act of 2006) in the event of specified funding deficiencies under the Plan. These provisions shall operate only if the funding targets defined herein are not met and shall apply only for the duration of the applicable funding deficiency.

(a) **Effective Date and Application of Schedule.**

(1) Effective Date. The provisions of this Schedule apply to Plan Years beginning on or after January 1, 2008, provided that in the event the Plan is determined to be a collectively-bargained plan for purposes of Treasury Regulations Section 1.436-1(a)(5)(ii)(B), the provisions of this Schedule apply to Plan Years beginning on or after the earlier of (a) January 1, 2010 or (b) the later of (1) the date on which the last collective bargaining agreement relating to the Plan and ratified before January 1, 2008 terminates, without regard to extensions agreed to after August 17, 2006, or (2) January 1, 2008.

(2) Notwithstanding anything in this Schedule III to the contrary, the provisions of Code Section 436 and the Regulations thereunder are incorporated herein by reference.

(b) **Funding-Based Limitation on Shutdown Benefits and Other Unpredictable Contingent Event Benefits**

(1) In general. If a Participant is entitled to an "unpredictable contingent event benefit" payable with respect to any event occurring during any Plan Year, then such benefit may not be provided if the "adjusted funding target attainment percentage" for such Plan Year is:

(A) less than sixty percent (60%); or

(B) would be less than sixty percent (60%) percent taking into account such occurrence.

(2) Exemption. Paragraph (1) shall cease to apply with respect to any Plan Year, effective as of the first day of the Plan Year, upon payment by the Employer of a contribution (designated at the time of contribution as being for the purpose of avoiding the limitation of paragraph (1) and in addition to any minimum required contribution under Code Section 430) equal to:

(A) in the case of (b)(1)(A) above, the amount of the increase in the funding target of the Plan (under Code Section 430) for the Plan Year attributable to the occurrence referred to in paragraph (1), and

(B) in the case of (b)(1)(B) above, the amount sufficient to result in an "adjusted funding target attainment percentage" of sixty percent (60%).

(3) Unpredictable contingent event benefit. For purposes of this subsection, the term "unpredictable contingent event benefit" means any benefit payable solely by reason of:

(A) a plant shutdown (or similar event, as determined by the Secretary of the Treasury), or

(B) an event other than the attainment of any age, performance of any service, receipt or derivation of any compensation, or occurrence of death or disability.

(c) **Limitations on Plan Amendments Increasing Liability for Benefits**

(1) In general. No amendment which has the effect of increasing liabilities of the Plan by reason of increases in benefits, establishment of new benefits, changing the rate of benefit accrual, or changing the rate at which benefits become nonforfeitable may take effect during any Plan Year if the "adjusted funding target attainment percentage" for such Plan Year is:

(A) less than eighty percent (80%); or

(B) would be less than eighty percent (80%) taking into account such amendment.

(2) Exemption. Paragraph (1) above shall cease to apply with respect to any Plan Year, effective as of the first day of the Plan Year (or if later, the effective date of the amendment), upon payment by the Employer of a contribution (designated at the time of contribution as being for the purpose of avoiding the limitation of paragraph (1) and in addition to any minimum required contribution under Code Section 430) equal to--

(A) in the case of paragraph (c)(1)(A) above, the amount of the increase in the funding target of the Plan (under Code Section 430) for the Plan Year attributable to the amendment, and

(B) in the case of paragraph (c)(1)(B) above, the amount sufficient to result in an "adjusted funding target attainment percentage" of eighty percent (80%).

(3) Exception for certain benefit increases. Paragraph (1) shall not apply to any amendment which provides for an increase in benefits under a formula which is not based on a Participant's compensation, but only if the rate of such increase is not in excess of the contemporaneous rate of increase in average wages of Participants covered by the amendment.

(d) **Limitations on Accelerated Benefit Distributions**

(1) Funding percentage less than sixty percent (60%). If the Plan's "adjusted funding target attainment percentage" for a Plan Year is less than sixty percent (60%), then the Plan may not pay any "prohibited payment" with a Benefit Commencement Date on or after the applicable Section 436 measurement date (as defined in the final regulations under Code Section 436, hereinafter "Section 436 Measurement Date") for the Plan Year.

(2) Bankruptcy. During any period in which the Employer is a debtor in a case under Title 11, United States Code, or similar Federal or State law, the Plan may not pay any "prohibited payment." The preceding sentence shall not apply on or after the date on which the enrolled actuary of the Plan certifies that the "adjusted funding target attainment percentage" of the Plan for the Plan Year is not less than one hundred percent (100%).

(3) Limited payment if percentage at least sixty percent (60%) but less than eighty percent (80%) percent.

(A) In general. If the Plan's "adjusted funding target attainment percentage" for a Plan Year is sixty percent (60%) or greater but less than eighty percent (80%), then the Plan may not pay any "prohibited payment" with a Benefit Commencement Date on or after the applicable Section 436 Measurement Date for the Plan Year to the extent the amount of the payment exceeds the lesser of:

(i) fifty (50) percent of the amount of the payment which could be made without regard to this subsection, or

(ii) the present value (determined under guidance prescribed by the Pension Benefit Guaranty Corporation, using the interest and mortality assumptions under Code Section 417(e)) of the maximum guarantee with respect to the participant under ERISA Section 4022.

(B) One-time application.

(i) In general. Only one "prohibited payment" meeting the requirements of subparagraph (A) may be made with respect to any Participant during any period of consecutive Plan Years to which the limitations under either paragraph (1) or (2) or this paragraph applies.

(ii) Treatment of beneficiaries. For purposes of this subparagraph, a Participant and any Beneficiary (including an alternate payee, as defined in Code Section 414(p)(8)) shall be treated as one Participant. If the Accrued Benefit of a Participant is allocated to such an alternate payee and one or more other persons, the amount under subparagraph (A) shall be allocated among such persons in the same manner as the Accrued Benefit is allocated unless the qualified domestic relations order (as defined in Code Section 414(p)(1)(A)) provides otherwise.

(4) "Prohibited payment." For purposes of this subsection, the term "prohibited payment" means:

(A) any payment, based on the optional form of benefit elected, in excess of the monthly amount paid under a single life annuity (plus any Social Security supplements described in the last sentence of Code Section 411(a)(9)), to a Participant or Beneficiary whose Benefit Commencement Date occurs during any period a limitation under paragraph (1) or (2) is in effect,

(B) any payment for the purchase of an irrevocable commitment from an insurer to pay benefits, and

(C) any other payment specified by the Secretary by Regulations.

Such term shall not include the payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Participant.

(5) The limitations under this subsection (d) shall not apply to prohibited payments that are made to carry out the termination of the Plan in accordance with Section 21.08 and applicable law.

(6) Payment options in event of application of subsection (d). In the event the restrictions applicable under subsection (d) above become effective for the Plan as of an applicable Section 436 Measurement Date and, as a result of such restrictions, an optional form of benefit that is otherwise available under Section 10.03 of the Plan is not available as of a Participant's Benefit Commencement Date, the Participant (or, if applicable, his Beneficiary) may elect to:

(A) commence benefits with respect to the entire Accrued Benefit under the Plan in any other optional form of benefit (available under Section 10.03 at the same Benefit Commencement Date) that is not restricted and satisfies paragraph (3)(A) above;

(B) defer commencement of the payment of the Accrued Benefit (either in whole or solely with respect to the portion restricted under paragraph (3)) to the extent such deferral is permitted under the Plan in and accordance with the applicable qualification requirements, including Code Sections 411(a)(11) and 401(a)(9); or

(C) with respect to optional forms of benefit restricted under paragraph (3) above, receive the unrestricted portion of that elected optional form of benefit as of the elected Benefit Commencement Date and either receive the remaining restricted portion in an optional form of benefit at the same Benefit Commencement Date that would be permitted under subsection (d) or defer receipt as provided in subparagraph (B) above.

(e) **Limitation on Benefit Accruals for Plans with Severe Funding Shortfalls**

(1) In general. If the Plan's "adjusted funding target attainment percentage" for a Plan Year is less than sixty percent (60%), benefit accruals under the Plan shall cease as of the applicable Section 436 Measurement Date for the Plan Year.

(2) Exemption. Paragraph (1) shall cease to apply with respect to any Plan Year, effective as of the first day of the Plan Year, upon payment by the Employer of a contribution (designated at the time of contribution as being for the purpose of avoiding the limitation of paragraph (1) and in addition to any minimum required contribution under Code Section 430) equal to the amount sufficient to result in an "adjusted funding target attainment percentage" of sixty percent (60%).

(3) Temporary modification of limitation. In the case of the first Plan Year beginning during the period beginning on October 1, 2008, and ending on September 30, 2009, the provisions of paragraph (1) above shall be applied by substituting the Plan's "adjusted funding target attainment percentage" for the preceding Plan Year for such percentage for such Plan Year, but only if the "adjusted funding target attainment percentage" for the preceding year is greater.

(f) **Rules Relating to Contributions Required to Avoid Benefit Limitations**

(1) Security may be provided.

(A) In general. For purposes of this section, the "adjusted funding target attainment percentage" shall be determined by treating as an asset of the Plan any security provided by the Employer in a form meeting the requirements of subparagraph (B).

(B) Form of security. The security required under subparagraph (A) shall consist of:

(i) a bond issued by a corporate surety company that is an acceptable surety for purposes of ERISA Section 412,

(ii) cash, or United States obligations which mature in three (3) years or less, held in escrow by a bank or similar financial institution, or

(iii) such other form of security as is satisfactory to the Secretary and the parties involved.

(C) Enforcement. Any security provided under subparagraph (A) may be perfected and enforced at any time after the earlier of:

(i) the date on which the Plan terminates,

(ii) if there is a failure to make a payment of the minimum required contribution for any Plan Year beginning after the security is provided, the due date for the payment under section 430(j), or

(iii) if the "adjusted funding target attainment percentage" is less than sixty percent (60%) for a consecutive period of 7 years, the valuation date for the last year in the period.

(D) Release of security. The security shall be released (and any amounts thereunder shall be refunded together with any interest accrued thereon) at such time as the Secretary may prescribe in Regulations, including Regulations for partial releases of the security by reason of increases in the "adjusted funding target attainment percentage."

(2) Prefunding balance or funding standard carryover balance may not be used as a contribution to avoid limitations. No prefunding balance or funding standard carryover balance under Code Section 430(f) may be used under subsection (b), (c), or (e) as a contribution to satisfy any payment an Employer may make under any such subsection to avoid or terminate the application of any limitation under such subsection.

(3) Deemed reduction of funding balances:

(A) In general. Subject to subparagraph (B), in any case in which a benefit limitation under subsection (b), (c), (d), or (e) would (but for this subparagraph and determined without regard to subsection (b)(2), (c)(2), or (e)(2)) apply to such Plan for the Plan Year, the Employer shall be treated for purposes of this title as having made an election under Code Section 430(f) to reduce the prefunding balance or funding standard carryover balance by such amount as is necessary for such benefit limitation to not apply to the Plan for such Plan Year. Notwithstanding the foregoing, with respect to subsections (b), (c) or (e), such deemed election shall be optional for any year in which the Plan is not a collectively-bargained plan as determined under Treasury Regulations Section 1.436-1(a)(5)(ii)(B).

(B) Exception for insufficient funding balances. Subparagraph (A) shall not apply with respect to a benefit limitation for any Plan Year if the application of subparagraph (A) would not result in the benefit limitation not applying for such Plan Year.

(g) **Presumed Underfunding for Purposes of Benefit Limitations**

(1) Presumption of continued underfunding. In any case in which a benefit limitation under subsection (b), (c), (d), or (e) has been applied to a Plan with respect to the Plan Year preceding the current Plan Year, the "adjusted funding target attainment percentage" of the Plan for the current Plan Year shall be presumed to be equal to the "adjusted funding target attainment percentage" of the Plan for the preceding Plan Year until the enrolled actuary of the Plan certifies the actual "adjusted funding target attainment percentage" of the Plan for the current Plan Year.

(2) Presumption of underfunding after 10th month. In any case in which no certification of the "adjusted funding target attainment percentage" for the current Plan Year is made with respect to the Plan before the first day of the 10th month of such year, for purposes of subsections (b), (c), (d), and (e), such first day shall be deemed, for purposes of such subsection, to be a Section 436 Measurement Date of the Plan for the current Plan Year and the Plan's "adjusted funding target attainment percentage" shall be conclusively presumed to be less than sixty percent (60%) as of such first day.

(3) Presumption of underfunding after 4th month for nearly underfunded plans. In any case in which:

(A) a benefit limitation under subsection (b), (c), (d), or (e) did not apply to a Plan with respect to the Plan Year preceding the current Plan Year, but the "adjusted funding target attainment percentage" of the Plan for such preceding Plan Year was not more than ten (10) percentage points greater than the percentage which would have caused such subsection to apply to the Plan with respect to such preceding Plan Year, and

(B) as of the first day of the 4th month of the current Plan Year, the enrolled actuary of the Plan has not certified the actual "adjusted funding target attainment percentage" of the Plan for the current Plan Year, until the enrolled actuary so certifies, such first day shall be deemed, for purposes of such subsection, to be a Section 436 Measurement Date of the Plan for the current Plan Year and the "adjusted funding target attainment percentage" of the Plan as of such first day shall, for purposes of such subsection, be presumed to be equal to ten (10) percentage points less than the "adjusted funding target attainment percentage" of the Plan for such preceding Plan Year.

(h) **Treatment of Plan as of Close of Prohibited or Cessation Period.** The following provisions apply for purposes of applying this Section.

(1) Operation of Plan after period. Payments and accruals will resume effective as of the day following the close of the period for which any limitation of payment or accrual of benefits under subsection (d) or (e) applies.

(2) Treatment of affected benefits. Nothing in this subsection shall be construed as affecting the Plan's treatment of benefits which would have been paid or accrued but for this Section.

(3) Restoration of accruals. Notwithstanding the foregoing, any restoration of accruals that were limited under subsection (e) shall be treated as a plan amendment subject to the restrictions of subsection (c), except where the period of limitation of accruals under subsection (e) applied for a period of 12 months or less and the "adjusted funding target attainment percentage" after restoration of accruals is at least 60%.

(4) Effective date of plan amendments. If a plan amendment does not go into effect as of its effective date during a Plan Year due to the restrictions of subsection (c), but is permitted to take effect later in the Plan Year due to the cessation of such limitation, the amendment shall be effective as of the later of the first day of the Plan Year or the effective date of the amendment. If the amendment cannot take effect during such Plan Year, it shall be effective as of the earliest date permitted pursuant to the rules of Code Section 436(c).

(i) **Definitions.**

(1) The term "funding target attainment percentage" has the same meaning given such term by Code Section 430(d)(2), except as otherwise provided herein. However, in the case of Plan Years beginning in 2008, the "funding target attainment percentage" for the preceding Plan Year may be determined using such methods of estimation as the Secretary may provide.

(2) The term "adjusted funding target attainment percentage" means the "funding target attainment percentage" which is determined under paragraph (1) by increasing each of the amounts under subparagraphs (A) and (B) of Code Section 430(d)(2) by the aggregate amount of purchases of annuities for employees other than highly compensated employees (as defined in Code Section 414(q)) which were made by the Plan during the preceding two (2) Plan Years.

(3) Application to plans which are fully funded without regard to reductions for funding balances.

(A) In general. In the case of a Plan for any Plan Year, if the "funding target attainment percentage" is one hundred percent (100%) or more (determined and without regard to the reduction in the value of assets under Code Section 430(f)(4)), the "funding target attainment percentage" for purposes of paragraphs (1) and (2) shall be determined without regard to such reduction.

(B) Transition rule. Subparagraph (A) shall be applied to Plan Years beginning after 2007 and before 2011 by substituting for "one hundred percent (100%)" the applicable percentage determined in accordance with the following table:

In the case of a Plan Year beginning in calendar year:	The applicable percentage is:
2008	92%
2009	94%
2010	96%

(C) Limitation of transition rule. Subparagraph (B) shall not apply with respect to the current Plan Year unless, for each Plan Year beginning on or after January 1, 2008 and before the current Plan Year, the "funding target attainment percentage" (determined without regard to the reduction in the value of assets under Code Section 430(f)(4)) of the Plan for each preceding Plan Year beginning after 2007 was not less than the applicable percentage with respect to such preceding Plan Year determined under subparagraph (B).

Appendix A -- TCO Voluntary Incentive Retirement Program

1.1A Eligibility. Notwithstanding any provision of the Plan to the contrary, a Participant who meets the following requirements as of March 1, 2000, and who terminates employment on the VIRP Retirement Date, may elect to retire early under the Voluntary Incentive Retirement Program ("VIRP"):

(a) Participant is actively employed by TCO;

(b) Participant has Credited Service of at least five years; and

(c) Participant has attained at least age 50.

1.2A Participation. In order for an eligible Participant to retire under the VIRP, the Participant must sign and return the VIRP Release (in the form to be approved by the Employer) to the Plan Administrator on or between January 1, 2000 and January 31, 2000, at which time a Participant's eligibility to participate under the VIRP shall permanently expire.

1.3A Retirement Date. A Participant's VIRP Retirement Date shall be March 1, 2000, unless (1) two or more Participants who elect the VIRP are in the same employment category or the same functional area or (2) if a Participant who elects the VIRP is the sole employee in a critical position. In such case, the VIRP Retirement Dates of any such Participant may be deferred, based on seniority with the Employer, to the extent reasonably necessary to ensure the continued orderly operation of Employer's business. The deferred VIRP Retirement Date shall not be later than September 1, 2000. All service and age calculations shall be based on the Participant's actual retirement date.

1.4A Retirement Benefits. On his VIRP Retirement Date, a Participant shall be entitled to receive the greater of (a) or (b) below, where the comparison of benefits shall be based on the lump sum value as determined under Section 1.6A below:

(a) Enhanced Benefits. Retirement Benefits, as provided in Article V of the Plan, subject to the following changes:

(1) Three years of Credited Service shall be added to the Participant's total Credited Service for purposes of computing Basic Monthly Retirement Income or Basic Early Monthly Retirement Income under Sections 5.1 and 5.2 of the Plan;

(2) Three years shall be added to the Participant's age for purposes of determining Basic Monthly Retirement Income or Basic Early Monthly Retirement Income under Sections 5.1 and 5.2 of the Plan;

(3) If the Participant's age (after applying Section 1.4A(a)(2) hereof) is less than 55, the early retirement reductions required by Section 5.2 of the Plan shall be applied for all years prior to age 55 at the rate of 0.25 percent per month; and

(4) Supplemental Retirement Income, as defined in Section 5.3 of the Plan, shall be determined using the Participant's Credited Service as determined in Section 1.4A(a)(1) hereof and shall commence upon the Participant's VIRP

Retirement Date. For purposes of this definition, the rate shall be $16.00 per year of Credited Service, up to a maximum of 30 years; or

(b) Special Minimum Benefit. The Special Minimum Benefit shall be equal to the sum of the following:

(1) Basic Monthly Retirement Income or Basic Early Monthly Retirement Income, as follows:

(A) if the Participant's benefit will commence after his Normal Retirement Date based on actual age and service, Basic Monthly Retirement Income as defined in Section 5.1 of the Plan; or

(B) if the Participant is eligible for Early Retirement under Section 4.1 based on actual age and service, Basic Early Monthly Retirement Income as defined in Section 5.2 of the Plan; or

(C) if the Participant is not eligible under either Section 1.4A(b)(1)(A) or (B) of this Section, Basic Early Monthly Retirement Income as defined in Section 5.2 of the Plan as if the Participant had reached his Earliest Retirement Date (the first date on which the Participant would be able to retire under Section 4.1 of the Plan). The benefit shall be reduced for payment prior to the Earliest Retirement Date based on actuarial equivalence, in accordance with the assumptions specified in Section 1.6A below; plus

(2) Supplemental Retirement Income, as defined in Section 5.3 of the Plan, determined using a rate of $16.00 per year of Credited Service. This benefit shall not be available if the Participant is not eligible for Early Retirement under Section 4.1 of the Plan based on his actual age and service as of the VIRP Retirement Date; plus

(3) A Special Benefit equal to a lump sum of five percent of the Participant's final annual base pay rate at the VIRP Retirement Date times years of Credited Service up to a maximum of 25 years. All of the benefits defined in this Section 1.4A(b) shall be based on the Participant's actual age and Credited Service as of the VIRP Retirement Date, excluding the extra years provided for in Sections 1.4A(a)(1) and (a)(2) above.

1.5A Normal Form of Payment. A Participant may elect to receive his entire VIRP Retirement Benefit in the form of an annuity described in Section 6.1 or Section 6.2 of the Plan; or a lump sum payable immediately, based on the assumptions in Section 1.6A below. In computing the amount of any life annuity due to the Special Benefit in Section 1.4A(b)(3) above, the lump sum amount in Section 1.4A(b)(3) shall be converted to an actuarially equivalent life annuity based on the assumptions in Section 1.6A below.

(a) In computing the amount of VIRP Retirement Benefits, the Participant shall be entitled to receive the greater of the amount computed using the Participant's actual VIRP Retirement Date or the amount computed using March 1, 2000 as the Participant's Retirement Date.

(b) Lump sums for retirements occurring on March 1, 2000, shall be computed using the lump sum rate under the Plan in effect for that month. For retirements occurring after March 1, 2000, lump sums shall be computed using the lesser of:

(1) The lump sum rate in effect for March 1, 2000 retirements; or

(2) The lump sum rate in effect for the actual month of retirement.

1.6A Actuarial Assumptions. Except as provided herein, the assumptions and factors used to compute VIRP benefits shall be those set forth in the Plan in effect on January 1, 2000, or as later amended if applicable.

1.7A Account Balance Formula. Employees who elect to retire early under the VIRP shall not be eligible to participate in the Plan's AB I, effective January 1, 2000, except as otherwise provided in the Plan's reemployment provisions.

1.8A Plan Shall Govern. Except as provided above, all reference to specific sections of the "Plan" in this Appendix refer to plan documents in effect on December 31, 1999, and the Plan benefit formula and accrual provisions in effect on December 31, 1999 shall govern all VIRP benefits.

Appendix B -- CDC/CS Voluntary Incentive Retirement Program

1.1B Eligibility. Notwithstanding any provision of the Plan to the contrary, a Participant who meets the following requirements as of June 1, 2000, and who terminates employment on the VIRP Retirement Date, may elect to retire early under the Voluntary Incentive Retirement Program ("VIRP"):

(a) Participant is actively employed by one of the following (collectively referred to as "CDC/CS"):

(1) Columbia Gas of Ohio, Inc.;

(2) Columbia Gas of Kentucky, Inc.;

(3) Columbia Gas of Maryland, Inc.;

(4) Columbia Gas of Pennsylvania, Inc.;

(5) Columbia Gas of Virginia, Inc.; or

(6) Any of the following departments of Columbia Energy Group Service Corporation:

(A) Air Transportation;

(B) Building and Administrative Services – Herndon and Marble Cliff;

(C) Client Support;

(D) Common Corporate Systems;

(E) Consolidated Financial Reporting;

(F) Corporate Communications;

(G) Corporate Finance;

(H) EMC Architecture/Network/Services;

(I) Enterprise Multimedia;

(J) Finance – Executive/Administrative;

(K) Financial Planning;

(L) General Accounting;

(M) Governmental Affairs;

(N) Information Systems;

(O) Payroll;

(P) System Financial Reporting; or

(Q) Tax;

(b) Participant has Credited Service of at least five years; and

(c) Participant has attained at least age 50.

1.2B Participation. In order for an eligible Participant to retire under the VIRP, the Participant must sign and return the VIRP Release (in the form to be approved by the Employer) to the Plan Administrator on or between April 1, 2000 and May 1, 2000, at which time a Participant's eligibility to participate under the VIRP shall permanently expire. The Participant must also sign and return an additional release (in the form to be approved by the Employer) on or before the Participant's VIRP Retirement Date.

1.3B Retirement Date. A Participant's VIRP Retirement Date shall be June 1, 2000, unless (1) two or more Participants who elect the VIRP are in the same employment category or functional area or (2) a Participant who elects the VIRP is the sole employee in a critical position. In such case, the VIRP Retirement Date of any such Participant may be deferred to the first day of a later month, based on seniority with the Employer, to the extent reasonably necessary to ensure the continued orderly operation of the Employer's business. Any deferred VIRP Retirement Date shall not be later than December 1, 2000. All service and age calculations shall be based on the Participant's actual retirement date.

1.4B Retirement Benefits. On his VIRP Retirement Date, a Participant shall be entitled to receive the greater of (a) or (b) below, where the comparison of benefits shall be based on the lump sum value as determined under Section 1.6B below:

(a) Enhanced Benefits. Retirement Benefits, as provided in Article V of the Plan, subject to the following changes:

(1) Three years of Credited Service shall be added to the Participant's total Credited Service for purposes of computing Basic Monthly Retirement Income or Basic Early Monthly Retirement Income under Sections 5.1 and 5.2 of the Plan;

(2) Three years shall be added to the Participant's age for purposes of determining Basic Monthly Retirement Income or Basic Early Monthly Retirement Income under Sections 5.1 and 5.2 of the Plan;

(3) If the Participant's age (after applying Section 1.4B(a)(2) hereof) is less than 55, the early retirement reductions required by Section 5.2 of the Plan shall be applied for all years prior to age 55 at the rate of 0.25 percent per month; and

(4) Supplemental Retirement Income, as defined in Section 5.3 of the Plan, shall be determined using the Participant's Credited Service as determined in Section 1.4B(a)(1) hereof and shall commence upon the Participant's VIRP Retirement Date. For purposes of this definition, the rate shall be $16.00 per year of Credited Service, up to a maximum of 30 years; or

(b) Special Minimum Benefit. The Special Minimum Benefit shall be equal to the sum of the following:

(1) Basic Monthly Retirement Income or Basic Early Monthly Retirement Income, as follows:

(A) if the Participant's benefit will commence after his Normal Retirement Date based on actual age and service, Basic Monthly Retirement Income as defined in Section 5.1 of the Plan; or

(B) if the Participant is eligible for Early Retirement under Section 4.1 based on actual age and service, Basic Early Monthly Retirement Income as defined in Section 5.2 of the Plan; or

(C) if the Participant is not eligible under either Section 1.4B(b)(1)(A) or (B) of this Section, Basic Early Monthly Retirement Income as defined in Section 5.2 of the Plan as if the Participant had reached his Earliest Retirement Date (the first date on which the Participant would be able to retire under Section 4.1 of the Plan). The benefit shall be reduced for payment prior to the Earliest Retirement Date based on actuarial equivalence, in accordance with the assumptions specified in Section 1.6B below; plus

(2) Supplemental Retirement Income, as defined in Section 5.3 of the Plan, determined using a rate of $16.00 per year of Credited Service. This benefit shall not be available if the Participant is not eligible for Early Retirement under Section 4.1 of the Plan based on his actual age and service as of the VIRP Retirement Date; plus

(3) A Special Benefit equal to a lump sum of five percent of the Participant's final annual base pay rate at the VIRP Retirement Date times years of Credited Service up to a maximum of 25 years. All of the benefits defined in this Section 1.4B(b) shall be based on the Participant's actual age and Credited Service as of the VIRP Retirement Date, excluding the extra years provided for in Sections 1.4B(a)(1) and (a)(2) above.

1.5B Normal Form of Payment. A Participant may elect to receive his entire VIRP Retirement Benefit in the form of an annuity described in Section 6.1 or Section 6.2 of the Plan; or a lump sum payable immediately, based on the assumptions in Section 1.6B below. In computing the amount of any life annuity due to the Special Benefit in Section 1.4B(b)(3) above, the lump sum amount in Section 1.4B(b)(3) shall be converted to an actuarially equivalent life annuity based on the assumptions in Section 1.6B below.

(a) In computing the amount of VIRP Retirement Benefits, the Participant shall be entitled to receive the greater of the amount computed using the Participant's actual VIRP Retirement Date or the amount computed using June 1, 2000 as the Participant's Retirement Date.

(b) Lump sums for retirements occurring on June 1, 2000, shall be computed using the lump sum rate under the Plan in effect for that month. For retirements occurring after June 1, 2000, lump sums shall be computed using the lesser of:

(1) The lump sum rate in effect for June 1, 2000 retirements; or

(2) The lump sum rate in effect for the actual month of retirement.

1.6B Actuarial Assumptions. Except as provided herein, the assumptions and factors used to compute VIRP benefits shall be those set forth in the Plan in effect on January 1, 2000, or as later amended if applicable.

1.7B Plan Shall Govern. Except as provided above, all reference to specific sections of the "Plan" in this Appendix refer to the plan document in effect on December 31, 1999, and the Plan benefit formula and accrual provisions in effect on December 31, 1999 shall govern all VIRP benefits.

Appendix C -- January 2001 Voluntary Early Retirement Program

1.1C Eligibility. Notwithstanding any provision of the Plan to the contrary, a Participant who meets the following requirements as of January 1, 2001, and who terminates employment on the VERP Retirement Date, may irrevocably elect to retire early under the Voluntary Early Retirement Program ("VERP"):

(a) Participant is actively employed by one of the following (collectively referred to as "Qualifying Employers"):

(1) Columbia Gas of Ohio, Inc.;

(2) Columbia Gas of Kentucky, Inc.;

(3) Columbia Gas of Maryland, Inc.;

(4) Columbia Gas of Pennsylvania, Inc.;

(5) Columbia Gas of Virginia, Inc.;

(6) Columbia Energy Group Service Corporation;

(7) Columbia Natural Resources; or

(8) Columbia Service Partners;

(b) Participant has Credited Service of at least five years;

(c) Participant has attained at least age 50; and

(d) Participant is not a party to a change-in-control agreement with his Employer.

1.2C Participation. In order for an eligible Participant to retire under the VERP, the Participant must sign and return the VERP Release (in the form to be approved by the Employer) to the Plan Administrator on or between November 2, 2000 and December 15, 2000, at which time a Participant's eligibility to participate under the VERP shall permanently expire. Once the VERP Release had been returned to the Plan Administrator, the Participant's election to retire under this VERP shall be irrevocable, except as otherwise required by law.

1.3C Retirement Date. A Participant's VERP Retirement Date shall be January 1, 2001, unless (1) two or more Participants who elect the VERP are in the same employment category or functional area or (2) a Participant who elects the VERP is the sole employee in a critical position. In such case, the VERP Retirement Date of any such Participant may be deferred to the first day of a later month, based on seniority with the Employer, to the extent reasonably necessary to ensure the continued orderly operation of the Employer's business. Any deferred VERP Retirement Date shall not be later than July 1, 2001. All service and age calculations shall be based on the Participant's actual retirement date.

1.4C Retirement Benefits. On his VERP Retirement Date, regardless of whether the Participant is a FAP Participant or an AB I Participant, a Participant shall be entitled to receive the greater of (a) or (b) below, where the comparison of benefits shall be based on the lump sum value as determined under Section 1.6C below:

(a) Enhanced Benefits. FAP Benefits, as provided in Article V of the Plan, as if the Participant's entire period of participation has been in the FAP Benefit, and not the AB I Benefit, subject to the following changes:

(1) Three years of Credited Service shall be added to the Participant's total Credited Service for purposes of computing the FAP Benefit under Section 5.2 of the Plan;

(2) Three years shall be added to the Participant's age for purposes of determining the FAP Benefit under Section 5.2 of the Plan;

(3) If the Participant's age (after applying Section 1.4C(a)(2) hereof) is less than 55, the early retirement reductions required by Section 7.3(b)(2) of the Plan shall be applied for all years prior to age 55 at the rate of 0.25 percent per month; and

(4) Supplemental Retirement Income, as defined in Section 5.3 of the Plan, shall be determined using the Participant's Credited Service as determined in Section 1.4C(a)(1) hereof and shall commence upon the Participant's VERP Retirement Date. For purposes of this definition, the rate shall be $16.00 per year of Credited Service, up to a maximum of 30 years; or

(b) Special Minimum Benefit. The Special Minimum Benefit shall be equal to the sum of the following:

(1) The FAP Benefit, as follows:

(A) if the Participant's benefit will commence after his Normal Retirement Date based on actual age and service, the FAP Benefit as defined in Section 5.2 of the Plan; or

(B) if the Participant is eligible for Early Retirement under Section 7.3 based on actual age and service, the FAP Benefit as defined in Section 7.3(b)(2) of the Plan; or

(C) if the Participant is not eligible under either Section 1.4C(b)(1)(A) or (B) of this Section, the FAP Benefit as defined in Section 7.3(b)(2) of the Plan as if the Participant had reached his Early Retirement Date (the first date on which the Participant would be able to retire under Section 7.3(a) of the Plan). The benefit shall be reduced for payment prior to the Earliest Retirement Date based on actuarial equivalence, in accordance with the assumptions specified in Section 1.6C below; plus

(2) Supplemental Retirement Income, as defined in Section 5.3 of the Plan, determined using a rate of $16.00 per year of Credited Service. This benefit shall not be available if the Participant is not eligible for Early Retirement under Section 7.3(a) of the Plan based on his actual age and service as of the VERP Retirement Date; plus

(3) A Special Benefit equal to a lump sum of five percent of the Participant's final annual base pay rate at the VERP Retirement Date times years of Credited Service up to a maximum of 25 years. All of the benefits defined in this Section 1.4C(b) shall be based on the Participant's actual age and Credited Service as of the VERP Retirement Date, excluding the extra years provided for in Sections 1.4C(a)(1) and (a)(2) above.

1.5C Normal Form of Payment. A Participant may elect to receive his entire VERP Retirement Benefit in the form of an annuity described in Section 8.3(a) or Section 8.3(c) of the Plan; or a lump sum payable immediately, based on the assumptions in Section 1.6C below. In computing the amount of any life annuity due to the Special Benefit in Section 1.4C(b)(3) above, the lump sum amount in Section 1.4C(b)(3) shall be converted to an actuarially equivalent life annuity based on the assumptions in Section 1.6C below.

(a) In computing the amount of VERP Retirement Benefits, the Participant shall be entitled to receive the greater of the amount computed using the Participant's actual VERP Retirement Date or the amount computed using January 1, 2001 as the Participant's Retirement Date.

(b) Lump sums for retirements occurring on January 1, 2001, shall be computed using the lump sum rate under the Plan in effect for that month. For retirements occurring after January 1, 2001, lump sums shall be computed using the lesser of:

(1) The lump sum rate in effect for January 1, 2001 retirements; or

(2) The lump sum rate in effect for the actual month of retirement.

1.6C Actuarial Assumptions. Except as provided herein, the assumptions and factors used to compute VERP benefits shall be those set forth in the Plan in effect on January 1, 2000, or as later amended if applicable.

1.7C Plan Shall Govern. Except as provided above, all reference to specific sections of the "Plan" in this Appendix refer to the plan document in effect on January 1, 2000, and the Plan benefit formula and accrual provisions in effect on January 1, 2000 shall govern all VERP benefits.

Appendix D -- 2002 Workforce Reduction Window

1.1D Eligibility. Notwithstanding any provision of the Plan to the contrary, the provisions of this Appendix D shall be applicable to each Participant who satisfies the following requirements, and who terminates employment on the Window Retirement Date.

(a) The Participant is designated as eligible to participate in the Columbia 2002 Workforce Reduction Window (the "Window") by written notice delivered to him by or on behalf of the Committee.

(b) The Participant has not been notified of his involuntary severance from employment by any Employer on or before April 15, 2002.

1.2D Participants. In order for an eligible Participant to retire under the Window, the Participant must sign and return the appropriate forms to the Committee during his 45 day election consideration period, at which time a Participant's eligibility to participate under the Window shall permanently expire.

1.3D Retirement Date. A Participant's Window Retirement Date shall be August 1, 2002 or, at the discretion of the Company, such other date as the Company deems appropriate.

1.4D Retirement Benefits. Each Participant in the Window who satisfies the above requirements shall be permitted to retire in accordance with the provisions of this Appendix D, and the following benefits shall be available to such Participant:

(a) A FAP Participant who terminates employment under the Window and who is between the ages of 50 and 52 as of December 31, 2002, with ten or more years of Vesting Service, may, at his election, receive either:

(1) A FAP Benefit, determined in accordance with Section 5.2 and commencing on his Normal Retirement Date, based upon his Final Average Annual Compensation and Credited Service at the time of termination of employment under the Window; or

(2) A FAP Benefit, commencing at the time of his termination of employment under the Window, or on the first day of any month thereafter prior to his Normal Retirement Date, determined in accordance with Section 5.2 based upon his Final Average Annual Compensation and Credited Service at the time of termination of employment under the Window, reduced to its full Actuarial Equivalent with respect to the period between the date the Benefit commences and the date the Participant attains age 55, further reduced by 0.25 percent for each month during the period commencing on the date he attains age 55 and ending on the date that is three years prior to his Social Security Retirement Age, and unreduced with respect to any period thereafter.

(b) A Participant who retires under the Window and who is between the ages of 53 and 55 as of December 31, 2002 shall be deemed to be on leave of absence from the date of his absence from employment under the Window until the date the Participant attains age 55, and shall be entitled to the following benefit:

(1) if the Participant participates in the Final Pay Option, he shall receive Vesting and Credited Service from the date of his absence from employment to the date the Participant attains age 55, at which time such Participant's FAP Benefit (based on his Final Average Annual

Compensation determined on the date his leave of absence commences) shall be calculated in accordance with (a) above.

(2) if the Participant participates in the AB I Benefit, he shall receive Point Service, Vesting Service, Pay-Based Credits (based on his Compensation at the rate in effect on the date the leave of absence commences) and Interest Credits from the date of his absence from employment to the date the Participant attains age 55, at which time such Participant shall be entitled to an AB I Benefit determined pursuant to Section 7.3.

(c) A Participant who retires under the Window and who is age 55 or older shall receive a retirement benefit determined in accordance with Article V or VI, as applicable.

1.5D. Plan Shall Govern. Except as provided above, all reference to specific sections of the "Plan" in this Appendix refer to the plan document in effect on December 31, 2002, and the Plan benefit formula and accrual provisions in effect on December 31, 2002 shall govern all Window benefits.

COLUMBUS/1737372v.6

FIRST AMENDMENT
TO THE
COLUMBIA ENERGY GROUP PENSION PLAN

Background Information

A. Columbia Energy Group (the "Company") maintains the Columbia Energy Group Pension Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The Company is a member of the NiSource, Inc. ("NiSource") controlled group of companies.

C. The NiSource Benefits Committee (the "Committee") has the power to amend and modify the Plan pursuant to Section 21.02 thereof.

D. On July 1, 2015 (the "Effective Date"), NiSource implemented the spin-off of its pipeline and transmission business, comprised of Columbia Pipeline Group, Inc. and its related entities, to become independent and non-related to NiSource (the "CPG Spin-Off").

E. The Committee desires to amend the introduction of the Plan, as of the Effective Date, to describe the CPG Spin-Off and address its impact on the Plan.

F. The Committee, as of the Effective Date, further desires to amend Schedule I, regarding Participating Employers, which is an informational attachment not formally part of the Plan, to reflect the changes in the participation of employers in the Plan resulting from the CPG Spin-Off.

Plan Amendment

1. The portion of the introduction of the Plan entitled Plan Background, regarding the history of the Plan, is amended by the addition of the following paragraph, included at the end of the last sentence of the Plan Background section:

> Effective as of the July 1, 2015, NiSource implemented the spin-off of its pipeline and transmission business, comprised of the Columbia Pipeline Group, Inc. ("CPG") and its related entities (collectively, the "CPG Entities"), to become independent and non-related to NiSource (the "CPG Spin-Off"). Prior to July 1, 2015, Employees of the CPG Entitles participated in either the Plan or the NiSource Salaried Pension Plan (the "Salaried Plan"). Effective July 1, 2015, in connection with the above-described corporate spin-off, the NiSource Benefits Committee, Plan Administrator and Named Fiduciary having amendment authority over the Plan and the Salaried Plan, authorized the transfer of assets and liabilities of certain Participants and Former Participants in the Plan and/or the Salaried Plan to the Columbia Pipeline Group Pension Plan (comprised of its component parts the Columbia Pipeline Group (CEG) Pension Plan and the Columbia Pipeline Group (NiSource Salaried) Pension Plan). Pursuant to said transfer and the existing terms of the

Plan, effective July 1, 2015, the Plan terms no longer apply to the above-mentioned Participants.

2. Effective July 1, 2015, Schedule I, regarding Participating Employers, which is an informational attachment not formally part of the Plan, is amended in its entirety to reflect the CPG Spin-Off, and shall read as follows:

Schedule I
List of Participating Employers

PARTICIPATING EMPLOYERS IN THE
COLUMBIA ENERGY GROUP PENSION PLAN

Name of Participating Employer

1. Columbia Energy Group
2. Columbia Gas of Kentucky
3. Columbia Gas of Maryland
4. Columbia Gas of Ohio
5. Columbia Gas of Pennsylvania
6. Columbia Gas of Virginia
7. Columbia Deep Water Services Company

Historical note: Prior to the Spin-off, along with the entities named above, the following were listed as Participating Employers: CNS Microwave, Inc., Columbia Gulf Transmission, LLC, and Columbia Gas Transmission, LLC.

3. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this First Amendment to the Columbia Energy Group Pension Plan to be executed on its behalf, by one of its members duly authorized, to be effective July 1, 2015 or such other date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Date: 6/22/15

NISOURCE SALARIED PENSION PLAN

Amended and Restated effective as of January 1, 2014

December 2014

Table of Contents

Page

ARTICLE I DEFINITIONS AND CONSTRUCTION 1
1.01 AB I Account 1
1.02 AB I Benefit 1
1.03 AB I Participant 1
1.04 AB II Account 1
1.05 AB II Benefit 1
1.06 AB II Participant 1
1.07 Accrued Benefit 1
1.08 Actuarial Equivalent 1
1.09 Authorized Leave of Absence 3
1.10 Beneficiary 3
1.11 Benefit Commencement Date 3
1.12 Break in Service 4
1.13 Code 4
1.14 Committee 4
1.15 Company 4
1.16 Compensation 4
1.17 Conversion Date 7
1.18 Credited Service 8
1.19 Disability/Disabled 8
1.20 Early Retirement Age 8
1.21 Early Retirement Date 8
1.22 Effective Date 8
1.23 Eligible Employee 8
1.24 Employee 9
1.25 Employer 9
1.26 ERISA 9
1.27 Exempt Employee 10
1.28 FAP Benefit 10
1.29 FAP Participant 10
1.30 Final Average Pay 10
1.31 Former Kokomo Employee 10
1.32 Former NIFL Employee 10
1.33 Highly Compensated Employee 10
1.34 Hour of Service 11
1.35 Interest Credits 11
1.36 Late Retirement Date 11
1.37 Kokomo 11
1.38 Leased Employee 11
1.39 Maximum Primary Social Security Benefit. 12
1.40 Next Gen Employee 12
1.41 NIFL 12
1.42 NIPSCO 12
1.43 NiSource 12
1.44 Non-Exempt Employee 12
1.45 Normal Retirement Age 12
1.46 Normal Retirement Date 12

Table of Contents

Page

1.47 Opening Balance 12
1.48 Participant 12
1.49 Pay-Based Credits 13
1.50 Plan 13
1.51 Plan 2006 Restatement 13
1.52 Plan Administrator 13
1.53 Plan Sponsor 13
1.54 Plan Year 13
1.55 Point Service 13
1.56 Protected Benefit 13
1.57 Related Employer 13
1.58 Severance from Service. 13
1.59 Single Life Annuity 13
1.60 Social Security Retirement Age 13
1.61 Spouse 14
1.62 Subsidiary Plan 14
1.63 Taxable Wage Base 14
1.64 Termination of Service 14
1.65 Treasury Regulations 14
1.66 Trust 14
1.67 Trust Agreement 14
1.68 Trustee 14
1.69 Union Employee 14
1.70 Union Plan 14
1.71 Vested/Nonforfeitable 14
1.72 Vesting Service 14
1.73 Terms Defined Elsewhere 14

ARTICLE II SERVICE PROVISIONS 16
2.01 Vesting Service 16
2.02 Credited Service 16
2.03 Point Service 17
2.04 Special Service Rules 17
2.05 Severance from Service 20
2.06 Break in Service 20

ARTICLE III PARTICIPATION AND TRANSFERS 21
3.01 Date of Participation 21
3.02 Participation Upon Reemployment 21
3.03 Continuation of Participation 21
3.04 Transfers 22
3.05 Conditions of Participation 25

ARTICLE IV AB II BENEFIT 26
4.01 Applicability of Article 26
4.02 AB II Benefit 26
4.03 AB II Account 27
4.04 Pay-Based Credits 28

Table of Contents

Page

4.05 Interest Credits 29
4.06 No Supplement for Age 60 Retirement 30
4.07 Protected Benefit for AB II Participant 30
4.08 Transition of Participants to the AB II Benefit 30

ARTICLE V AB I BENEFIT 32
5.01 Applicability of Article 32
5.02 AB I Benefit 32
5.03 AB I Account 33
5.04 Pay-Based Credits 34
5.05 Interest Credits 34
5.06 Supplement for Age 60 Retirement 35
5.07 Protected Benefit for an AB I Participant 36

ARTICLE VI FAP BENEFIT 37
6.01 Applicability of Article 37
6.02 FAP Benefit 37
6.03 Supplement for Age 60 Retirement 39
6.04 Grandfathered Pension Increases 40

ARTICLE VII RETIREMENT BENEFITS 42
7.01 Normal Retirement Benefit 42
7.02 Late Retirement Benefit 42
7.03 Early Retirement Benefit 43
7.04 Disability Benefit 44
7.05 Nonduplication of Benefits 45

ARTICLE VIII TERMINATION OF SERVICE; PARTICIPANT VESTING 46
8.01 Termination of Service Prior to Normal or Early Retirement or Death 46
8.02 Vesting 47
8.03 Included Years of Vesting Service 47
8.04 Deemed Cash-Out Provision for Non-Vested Participants 48

ARTICLE IX DEATH BENEFITS 49
9.01 Death On Or After Benefit Commencement Date 49
9.02 Death Prior to Benefit Commencement Date 49
9.03 Additional Death Benefit Payment Provisions 51
9.04 Preretirement Survivor Annuity Requirements 51
9.05 Beneficiary Designation 53
9.06 Failure of Beneficiary Designation 53
9.07 Facility of Payment 53

ARTICLE X TIME AND METHOD OF PAYMENT OF BENEFITS 55
10.01 Automatic Form of Benefit Payment 55
10.02 Waiver Election - Qualified Joint And Survivor Annuity 56
10.03 Optional Forms of Benefit Distribution 57
10.04 Cash Out of Small Amounts 59
10.05 Claim for Benefits 60

Table of Contents

Page

10.06 Restrictions on Distribution Timing 60
10.07 Minimum Distribution Requirements 60
10.08 Purchase Of Nontransferable Annuity 66
10.09 Qualified Domestic Relations Order 67
10.10 Direct Rollovers 68
10.11 True-Up Amounts 69
10.12 Retroactive Annuity Starting Date 69

ARTICLE XI SUSPENSION OF BENEFITS UPON CERTAIN EMPLOYMENT OR REEMPLOYMENT 72
11.01 Suspension of Benefits 72
11.02 Benefits Upon Reemployment 73
11.03 Suspension of Benefits Notice 74

ARTICLE XII CONTRIBUTIONS 76
12.01 Employer Contributions 76
12.02 Determination of Employer Contribution 76
12.03 Time of Payment of Employer Contribution 76
12.04 Return of Employer Contributions 76
12.05 Application of Forfeitures 76
12.06 Employee Contributions 76

ARTICLE XIII LIMITATION ON BENEFITS 77
13.01 Effective Date 77
13.02 Annual Benefit 77
13.03 Other Defined Benefit Plans 77
13.04 Grandfather Provision 77
13.05 Coordination with Other Rules 77
13.06 Definitions 77
13.07 Other Rules 85

ARTICLE XIV EMPLOYER ADMINISTRATIVE PROVISIONS 87
14.01 Information To Plan Administrator 87
14.02 No Liability 87
14.03 Indemnity Of Committee 87

ARTICLE XV PARTICIPANT ADMINISTRATIVE PROVISIONS 88
15.01 Personal Data To Plan Administrator 88
15.02 Address For Notification 88
15.03 Notice Of Change In Terms 88
15.04 Assignment Or Alienation 88
15.05 Litigation Against The Plan 88
15.06 Information Available 88
15.07 Presenting Claims For Benefits 88
15.08 Claims Review Procedure 89
15.09 Disputed Benefits 90

ARTICLE XVI ADMINISTRATION 91

Table of Contents

Page

16.01 Allocation Of Responsibility Among Fiduciaries For Plan And Trust Administration....91
16.02 Appointment Of Committee....91
16.03 Committee Procedures....91
16.04 Other Committee Powers And Duties....91
16.05 Records And Reports....92
16.06 Rules And Decisions....92
16.07 Application And Forms For Benefits....93
16.08 Authorization Of Benefit Payments....93
16.09 Funding Policy....93
16.10 Unclaimed Accrued Benefit – Procedure....93
16.11 Fiduciary Duties....93
16.12 Allocation Or Delegation Of Duties And Responsibilities....93
16.13 Procedure For The Allocation Or Delegation Of Fiduciary Duties....94
16.14 Individual Statement....94
16.15 Recovery of Overpaid Benefits....94

ARTICLE XVII TRUST FUND....95
17.01 Establishment Of Trust....95
17.02 Investment Of Trust Assets....95
17.03 Fees And Expenses From Trust....95
17.04 Distribution Directions....95
17.05 Trust For Exclusive Benefit Of Participants Of The Plan And Their Beneficiaries....95

ARTICLE XVIII TOP HEAVY PROVISIONS....96
18.01 Minimum Benefit....96
18.02 Determination Of Top Heavy Status....96
18.03 Definitions....97
18.04 Application of Article....98

ARTICLE XIX MISCELLANEOUS....99
19.01 Evidence....99
19.02 No Responsibility For Employer Action....99
19.03 Fiduciaries Not Insurers....99
19.04 Waiver Of Notice....99
19.05 Successors....99
19.06 Word Usage....99
19.07 Headings....99
19.08 Governing Law and Venue....99
19.09 Employment Not Guaranteed....100

ARTICLE XX EXCLUSIVE BENEFIT; AMENDMENT; TERMINATION....101
20.01 Exclusive Benefit....101
20.02 Amendment To Plan or Trust....101
20.03 Amendment To Vesting Provisions....101
20.04 Merger/Direct Transfers And Elective Transfers....102
20.05 Discontinuance....102

Table of Contents

Page

20.06 Full Vesting On Termination 103
20.07 Partial Termination 103
20.08 Termination 103
20.09 Distribution Upon Termination Of Trust Fund 103
20.10 Manner Of Distribution 104
20.11 Overfunding 104
20.12 Special Restriction On Benefit 104

SCHEDULE I – LIST OF PARTICIPATING EMPLOYERS 106

SCHEDULE II – CASH BALANCE ELECTION PERIODS 107

SCHEDULE III –BENEFIT RESTRICTIONS PURSUANT TO CODE SECTION 436 110

APPENDIX A – SURVIVOR ANNUITY CALCULATIONS 117

APPENDIX B -- EARLY RETIREMENT INCENTIVE PROGRAM 118

APPENDIX C – SPECIAL EARLY RETIREMENT BENEFITS (1990-1997) 119

APPENDIX D – EARLY RETIREMENT REDUCTION FACTORS 120

APPENDIX E – SPECIAL EARLY RETIREMENT BENEFITS (1996/1997) 121

APPENDIX F – SPECIAL EARLY RETIREMENT BENEFITS (2000) 123

APPENDIX G – SPECIAL DISTRIBUTION BENEFIT (2002) 124

NISOURCE SALARIED PENSION PLAN

NiSource Inc. (the "Company") maintains the NiSource Pension Plan, the provisions of which are set forth in two plan documents: the NiSource Salaried Pension Plan and the NIPSCO Union Pension Plan. This Plan document sets forth the provisions of the NiSource Salaried Pension Plan (f/k/a the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Salaried and Non-Exempt Employees) (the "Plan"), which is maintained for the benefit of Eligible Employees of the Company, its subsidiary, Northern Indiana Public Service Company (the "Plan Sponsor") and any other Related Employer that adopts the Plan. The Plan is hereby amended and restated in its entirety effective as of January 1, 2014, and such other dates set forth herein.

Purpose

The Plan Sponsor established the Plan to provide for a portion of the livelihood of Participants and their beneficiaries in their retirement. The Plan and the related Trust are intended to meet the requirements of Section 401(a) and Section 501(a) of the Internal Revenue Code of 1986, as amended (the "Code"), and all other applicable statutory and regulatory requirements.

Special effective dates are included with respect to a number of provisions as necessary to conform to various legislation and guidance (including but not limited to): the Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA") (as such provisions were previously adopted and reflected in a restated plan document effective January 1, 2006 (the "Plan 2006 Restatement")); revisions required to comply with Code Section 415 (as such provisions were previously adopted by the Company in a separate Plan amendment); and changes to comply with the Pension Protection Act of 2006 ("PPA"). The NiSource Benefits Committee (the "Committee") amended and restated the Plan effective as of January 1, 2009 to reflect various design changes and to update the Plan in accordance with the legislative changes referenced above (the "Plan 2009 Restatement"); amended and restated the Plan effective as of January 1, 2010 (the "Plan 2010 Restatement") and effective as of January 1, 2011 (the "Plan 2011 Restatement"), in each instance to make certain clarifications with respect to the administration and operation of the Plan; and amended and restated the Plan effective as of January 1, 2013 to (1) reflect the merger of the NiSource Subsidiary Pension Plan with and into the Plan effective December 31, 2012, (2) provide that any Non-Exempt Employee hired or rehired on or after January 1, 2013 is no longer eligible to participate in the Plan and (3) make additional clarifications with respect to the administration and operation of the Plan (the "Plan Merger Restatement"). The Committee now amends and restates the Plan effective as of January 1, 2014 (and such other dates set forth herein) to make additional clarifications with respect to the administration and operation of the Plan (the "Plan 2014 Restatement").

The provisions of this amended and restated Plan shall apply solely to an Employee whose employment with the Employer terminates on or after the Effective Date (or with respect to the application of a specific Plan provision containing a different effective date, then such provision shall apply to an Employee who terminates on or after such effective date). An Employee whose employment with the Employer terminates prior to the Effective Date shall be entitled to a benefit, if any, as determined under the provisions of the Plan in effect on the date that his employment terminated.

Plan Background

Originally known as the "Northern Indiana Public Service Company Pension Plan," the Plan was established effective January 1, 1945. Effective as of March 1, 1981, the Plan was amended, restated and continued as one Plan (with one Trust), the "NiSource Pension Plan," but in two separate documents: (1) one document entitled Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Bargaining Unit Employees

(now known as the "NIPSCO Union Pension Plan") and (2) one document entitled Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Salaried and Non Exempt Employees (now known as the "NiSource Salaried Pension Plan"). This document sets forth the provisions of the NiSource Salaried Pension Plan, which prior to January 1, 2010 was referred to as the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining To Salaried and Non Exempt Employees.

Effective July 1, 2011, Northern Indiana Fuel and Light Company, Inc. (NIFL) and Kokomo Gas and Fuel Company ("Kokomo") were merged with and into Northern Indiana Public Service Company ("NIPSCO"), a wholly owned subsidiary of NiSource Inc. From July 1, 2011 until December 31, 2012, the employees of NIFL and Kokomo did not participate in the Plan but instead participated in either the NiSource Subsidiary Pension Plan ("Subsidiary Plan") or the Kokomo Union Pension Plan ("Kokomo Plan"). Effective December 31, 2012, the Subsidiary Plan and Kokomo Plan were merged into the NiSource Pension Plan, with non-union participants in those plans now governed by the Plan and all union participants in the merged plan now governed by the NIPSCO Union Pension Plan. Except as specifically provided in the Plan, effective as of December 31, 2012, the provisions of the Plan shall apply to Former Kokomo Employees and Former NIFL Employees as well as other Plan Participants.

The Plan has been amended and restated several times, including a Plan restatement effective as of January 1, 2002 to add a cash balance feature to the Plan and to meet additional statutory and regulatory requirements. In the Plan 2006 Restatement, the Plan was further amended and restated to provide for an additional cash balance feature to the Plan.

Since the Plan 2006 Restatement, and as reflected in the Plan 2009 Restatement, the Plan 2010 Restatement, the Plan 2011 Restatement, and the Plan Merger Restatement, the Plan was further amended to comply with certain legally-required changes and to reflect other design revisions, including the following: (1) providing that all Eligible Employees hired on or after January 1, 2008 (but before January 1, 2010, with respect to Exempt Employees) participate in the cash balance feature of the Plan referred to as the AB II Benefit (f/k/a Account Balance 2011 Option Benefit) as described in Article IV; (2) providing that all active Exempt Employees shall be subject to the AB II Benefit provisions described in Article IV on an after January 1, 2011 and that all Disabled Exempt Employees shall be subject to the AB II Benefit provisions described in Article IV on and after January 1, 2012; (3) providing that all Non-Exempt Employees shall be subject to the AB II Benefit provisions described in Article IV on and after January 1, 2013; (4) reflecting the merger of the NiSource Subsidiary Pension Plan with and into the Plan effective December 31, 2012; and (5) providing that any Non-Exempt Employee hired or rehired on or after January 1, 2013 is no longer eligible to participate in the Plan. Certain terminated or non-active Participants continue to be subject to the provisions providing for an AB I Benefit (f/k/a Account Balance Option Benefit) as described in Article V, or the Plan provisions providing for a FAP Benefit (f/k/a Final Pay Option Benefit) as described in Article VI. Appendices attached hereto describe the features of certain voluntary incentive and early retirement window programs.

ARTICLE I

DEFINITIONS AND CONSTRUCTION

As used herein, unless otherwise defined or required by the context, the following words and phrases shall have the meanings indicated. Some of the words and phrases used in the Plan are not defined in this Article I, but for convenience are defined as they are introduced into the text. The location of such terms is set forth at the end of this Article.

Whenever appropriate, words and terms defined in the singular may be read as the plural, and the plural may be read as the singular. Unless otherwise required by the context, masculine pronouns also shall include the feminine, and the feminine shall include the masculine. The headings of Articles and Sections are included solely for convenience, and if there is any conflict between such headings and the text of the Plan, the text shall control.

1.01 AB I Account. The bookkeeping account, the amount of which is determined in accordance with Section 5.03, from which a Participant's AB I Benefit is derived.

1.02 AB I Benefit. The portion of a Participant's Accrued Benefit that accrues in accordance with Section 5.02.

1.03 AB I Participant. A Participant who is accruing an AB I Benefit pursuant to Article V.

1.04 AB II Account. The bookkeeping account, the amount of which is determined in accordance with Section 4.03, from which a Participant's AB II Benefit is derived.

1.05 AB II Benefit. The portion of a Participant's Accrued Benefit that accrues in accordance with Section 4.02.

1.06 AB II Participant. A Participant who is accruing an AB II Benefit pursuant to Article IV.

1.07 Accrued Benefit. As of any given date, the monthly benefit determined in accordance with Section 4.02 (with respect to any AB II Participant), Section 5.02 (with respect to any AB I Participant) or Section 6.02 (with respect to any FAP Participant), as applicable, payable in the form of a Single Life Annuity commencing at Normal Retirement Date, or, if applicable, at Late Retirement Date, and considering as of the date of determination either the Participant's AB II Account or AB I Account (if applicable) or in the case of any FAP Participant, considering Credited Service and Final Average Pay. Notwithstanding the foregoing, however, a Participant's Accrued Benefit shall never be less than the Participant's Protected Benefit, if applicable. In addition, a Participant's Accrued Benefit shall be subject to any top heavy minimum benefit described in Article XVIII.

Notwithstanding any provision of the Plan to the contrary (including the Plan provisions relating to Code Section 417(e)), with respect to any AB II or AB I Participant, effective with respect to distributions made on or after January 1, 2008, the present value of a Participant's Vested Accrued Benefit for purposes of making a distribution of a Participant's entire Vested Accrued Benefit (including for purposes of complying with the requirements of Code Section 417(e)), shall be equal to the Participant's AB II Account or AB I Account, as applicable, subject also to any applicable Protected Benefit provision.

1.08 Actuarial Equivalent. A benefit of equal value computed by using factors intended to produce equality in the value of the aggregate amounts expected to be received under different forms and/or timing of benefits. Such equivalent value is determined on the basis of the interest rate, mortality table and other factors, if any, applicable to such other annuity or benefit, as in effect at the date of determination as specified below.

(a) In General. Unless specified otherwise in the Plan, for purposes of determining the Actuarial Equivalent, the Plan shall apply the "Plan Interest Rate" and the "Plan Mortality Table" as set forth in this subsection (a), subject to the Minimum Benefit requirements set forth in subsection (c) below.

(i) "Plan Interest Rate" shall be the annual rate of interest on 30-year Treasury Securities, as determined and published by the Internal Revenue Service, determined each Plan Year using the interest rate in effect for the month of September immediately preceding the first day of the Plan Year containing the Benefit Commencement Date (or with respect to the calculation of Opening Balances, for the month of September immediately preceding the first day of the Plan Year containing the Conversion Date).

(ii) "Plan Mortality Table" shall be the mortality table prescribed by the Internal Revenue Service as set forth in Revenue Ruling 2001-62 (commonly referred to as the 1994 GAR Mortality Table).

(b) Applicability. Except as set forth in subsection (c) or (d) below or specifically stated otherwise in the Plan, the Plan Interest Rate and the Plan Mortality Table shall be used in computing an Actuarial Equivalent benefit for all purposes under the Plan, including: (i) calculating the lump sum present value of a Participant's Accrued Benefit; (ii) calculating the lump sum present value of a Participant's Protected Benefit; (iii) determining an Opening Balance pursuant to Section 4.03(b) or Section 5.03(b); or (iv) converting an AB I Account or AB II Account to a Single Life Annuity.

In addition, for purposes of calculating a FAP Benefit under Article VI or a Participant's Protected Benefit, if the Benefit Commencement Date precedes the date the Participant reaches age 55 (or would have attained age 55, in the case of a death benefit for a FAP Participant), the Plan shall calculate such benefit using the Plan Interest Rate and the Plan Mortality Table, applying such factors to the age 65 benefit. If the Benefit Commencement Date is on or after the date the Participant reaches age 55 (or would have attained age 55, in the case of a death benefit for a FAP Participant), the Plan shall apply the foregoing factors to the immediately payable benefit (or Protected Benefit), with such benefit calculated in accordance with any early retirement reduction factors set forth in the Plan. This benefit commencing on or after age 55 shall be no less than the Actuarial Equivalent present value of the benefit deferred to age 65, applying the Minimum Interest Rate and Minimum Mortality Table (but not calculated as a deferred to 65 benefit applying the Plan Interest Rate and Plan Mortality Table).

(c) Minimum Calculation Provisions: Notwithstanding the foregoing, effective January 1, 2008, in accordance with the requirements of Code Section 417(e)(3), for purposes of calculating (i) the Actuarial Equivalent lump sum present value of a Participant's Accrued Benefit, (ii) the lump sum value of a Protected Benefit, or (iii) a Participant's Opening Balance, the Plan shall apply the Minimum Interest Rate and Minimum Mortality Table (defined herein) if such factors jointly produce a greater benefit than applying the Plan Interest Rate and Plan Mortality Table.

(i) "Minimum Interest Rate" shall be the "applicable interest rate" under Code Section 417(e)(3)(C) (commonly referred to as the "Corporate Bond Rate"), which is the adjusted first, second, and third segment rates applied under rules similar to the rules of Code Section 430(h)(2)(C) (determined without regard to the 24-month averaging provided under Code Section 430(h)(2)(D)(i) and applying the 5-year transition phase-in rule of Code Section 417(e)(3)(D)(ii)), determined each Plan Year using the interest rates in effect for the month of September immediately preceding the first day of the Plan Year containing the Benefit Commencement Date (or with respect to the calculation of Opening Balances, for the month of September immediately preceding the Conversion Date).

(ii) "Minimum Mortality Table" shall be the mortality table under Code Section 417(e)(3) that is prescribed by the Internal Revenue Service as set forth in Revenue Ruling 2007-67 and by subsequent guidance issued by the Internal Revenue Service.

(d) Special Conversion Factors. When converting a Single Life Annuity or a lump sum benefit into another form of payment under the Plan (other than a Single Life Annuity or a lump sum), the Actuarial Equivalent interest rate used shall be 8% per year and the mortality table used shall be the 1983 Group Annuity Mortality Table ("83 GAM"), based on a fixed blend of 50% male and 50% female.

(e) Effective January 1, 2008, a Participant's AB II Benefit equals his AB II Account. Prior to January 1, 2008, the lump sum Actuarial Equivalent of a Participant's AB II Benefit (which was expressed as a Single Life Annuity) was generally equal to his AB II Account, but in no event less than the Actuarial Equivalent of the AB II Benefit determined in accordance with subsection (a) above.

(f) Effective January 1, 2008, a Participant's AB I Benefit equals his AB I Account. Prior to January 1, 2008, the lump sum Actuarial Equivalent of a Participant's AB I Benefit (which was expressed as a Single Life Annuity) was generally equal to his AB I Account, but in no event less than the Actuarial Equivalent of the AB I Benefit determined in accordance with subsection (a) above.

1.09 Authorized Leave of Absence. Any absences (with or without Compensation) authorized by an Employer under the Employer's standard personnel practices, provided that all persons under similar circumstances must be treated alike in the granting of such Authorized Leaves of Absence, and provided further that the Participant returns within the period specified in the Authorized Leave of Absence. If a Participant does not resume work with the Employer, the date that the Authorized Leave of Absence ends shall be deemed the Participant's Termination of Service. An Authorized Leave of Absence shall include (i) a leave of absence authorized by an Employer pursuant to the provisions of the Family and Medical Leave Act and (ii) a leave of absence due to service in the Armed Forces of the United States to the extent required by Code Section 414(u)(effective with respect to re-employment initiated on or after December 12, 1994).

1.10 Beneficiary. The individual(s) or entity, determined pursuant to Section 9.05, who is or may become entitled to a benefit under the Plan. With respect to the death benefit of any FAP Participant, only a surviving Spouse can be the Beneficiary under the Plan. A Beneficiary who becomes entitled to a benefit under the Plan is a Beneficiary under the Plan until such benefit is fully distributed. A Beneficiary's right to information concerning the Plan, and the Plan Administrator's, the Committee's or the Trustee's duty to provide to the Beneficiary information concerning the Plan, does not arise until the Beneficiary first becomes entitled to receive a benefit under the Plan.

1.11 Benefit Commencement Date. A term used in the calculation of a Participant's benefit under the Plan and which shall be the first day of the month for which the Plan pays a benefit pursuant to Article VII (*i.e.*, on the Normal Retirement Date, Early Retirement Date or Late Retirement Date) or Article VIII (*i.e.*, on the Vested Retirement Date). Notwithstanding the foregoing, prior to January 14, 2010, Benefit Commencement Date shall mean: for an annuity form of distribution, the first day of the first period for which the Plan pays an amount as an annuity; for a lump sum payment, the first day of the month next following the date on which all events have occurred that entitles the Participant to the benefit. For purposes of establishing a Benefit Commencement Date within a particular Plan Year (*i.e.*, establishing a Benefit Commencement Date of no later than December 1st of such Plan Year), a Participant must terminate employment on or before November 30 of that year and timely comply with all procedural requirements established by the Plan Administrator (*e.g.*, initiation or completion (as required by the Plan Administrator) of distribution forms, consents, etc.).

1.12 Break in Service. A period of absence from employment, as defined in Section 2.06.

1.13 Code. The Internal Revenue Code of 1986, as amended from time to time.

1.14 Committee. The NiSource Benefits Committee, established and maintained pursuant to Article XVI to administer and amend the Plan.

1.15 Company. NiSource Inc., a Delaware corporation, or any successor to it in the ownership of substantially all its assets.

1.16 Compensation. Except to the extent modified for specific Participant groups (such as FAP Participants) as set forth below, Compensation means the base pay received by an Employee from an Employer. In general, Compensation shall be determined on a monthly basis. For a full-time Employee who is paid on a monthly, semi-monthly, biweekly, or weekly basis, monthly Compensation shall equal one-twelfth of the Employee's annual base rate of pay last in effect for the month, plus pay inclusions set forth below such as actual commissions paid in the month. For part-time Employees, monthly Compensation shall equal the sum of the actual Compensation, plus pay inclusions set forth below (such as commissions) paid to the Employee for each pay period during the month.

Compensation shall include the following: (1) one-time payments in lieu of salary increases for any Plan Year (referred to as "lump-sum merit pay") (included effective September 1, 2009); (2) amounts deferred and excluded from the Participant's taxable income pursuant to Code Sections 125, 132(f)(4), 402(e)(3), or 402(h)(1)(B); (3) commissions (to the extent an Employee is compensated in whole or in part on a commission basis); (4) performance-based pay received by an Employee from an Employer; and (5) solely with respect to Participants subject to the NiSource Vacation Policy ("Vacation Policy") and subject to any payment timing limitations set forth below, any amounts attributable to "banked" vacation (as that term is described in the Vacation Policy) during the calendar year including such Participant's Termination of Service. Effective January 1, 2009, for Participants on active duty in the uniformed services for a period of more than 30 days, Compensation shall include any differential wage payments, as defined by Code Section 3401(h)(2), to the extent such payments are made by the Employer. Such differential wage payments shall be treated as compensation for all Plan purposes, including Code Section 415 and any other Code section that references the definition of compensation under Code Section 415. A Participant receiving such differential wage payment shall be treated as an Employee of the Employer making the payment.

For purposes of the foregoing paragraph, "base pay" shall exclude various forms of compensation, including (but not limited to) the following: overtime, any amounts deferred to a nonqualified plan maintained by an Employer, and other special forms of compensation such as shift differential, call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income. Effective for limitations years beginning on or after July 1, 2007, for purposes of applying the limitations of Article XIII and to the extent otherwise included in Plan Compensation, Compensation generally shall exclude amounts paid after Termination of Service. However, Compensation shall include post-severance amounts set forth in items (i) and (ii) below to the extent such amounts are paid by the later of 2 ½ months after Termination of Service or by the end of the Plan Year (the Limitation Year for purposes of Article XIII) that includes the date of such Termination of Service. Provided the foregoing timing-of-payment condition is met, Compensation shall include:

(i) Regular pay paid after Termination of Service if: (a) the payment is regular compensation for services during the Participant's regular working hours, commissions, bonuses (to the extent included in Compensation by specific group), or other similar payments; and (b) the payment would have been paid to the Employee prior to a Termination of Service if the Employee had continued in employment with the Employer; and

(ii) To the extent otherwise included in Plan Compensation as described in this Section 1.16, payments of unused accrued bona fide sick, vacation, or other leave (but only if the Employee would have been able to use the leave if employment had continued).

(i) In clarification of the foregoing, Compensation excludes any incentive-based pay (such as payments from the corporate annual incentive plan or any plan created in lieu of the corporate annual incentive plan, commissions, spot awards, discretionary awards, lump-sum merit pay, and performance-based pay) when paid in any month following Termination of Service.

(a) Considerations by Specific Group. Subject to any limitations imposed by Code Section 415 as set forth in this Section, the following additional provisions regarding Compensation shall apply:

(i) AB II Participants and AB I Participants. For any AB II Participant or AB I Participant, the definition of Compensation set forth above shall apply with the following modifications: (1) for any AB II Participant or AB I Participant, Compensation shall exclude unused and accrued vacation paid on or after Termination of Service; and (2) for any AB I Participant, Compensation shall include shift differential earned by the Participant. For purposes of determining a Participant's Pay-Based Credits under Sections 4.04 or 5.04, Compensation means the sum of the monthly Compensation for each month during the Plan Year in which the Participant is an AB II Participant or AB I Participant, including actual bonuses received by the Employee while actively employed in the month.

(ii) FAP Participants. For any FAP Participant, the first paragraph of this Section (describing Compensation as "base pay" and the determination of same) shall not apply. Instead. Compensation is the total amount paid to an Employee for personal services that are considered as "wages" on Federal Income Tax Withholding Statement (Form W 2).

The Compensation inclusions set forth in the second paragraph of this Section 1.16 shall continue to apply with the following modification: with respect to performance-based pay, Compensation shall include any portion of bonuses paid to an Employee in a calendar year only to the extent such bonuses do not exceed 50% of an Employee's base pay (annualized if less than a full year) for such calendar year. If all or a portion of a bonus is deferred at the election of an Employee, it shall be treated as paid on the date it would have been paid without the election to defer for purposes of determining the 50% bonus threshold of the foregoing sentence (even though if deferred to a nonqualified plan, such deferral is excluded from Compensation as set forth below).

The first sentence of the third paragraph of this Section 1.16 (setting forth certain Compensation exclusions) shall be disregarded and the following Compensation exclusions shall apply: (1) severance pay; (2) amounts deferred to a nonqualified plan maintained by an Employer; (3) any portion of bonuses paid to an Employee in a calendar year to the extent it exceeds the 50% base pay threshold described in the foregoing paragraph; (4) sign-on bonuses, retention premiums, and attendance bonuses and awards; and (5) all other taxable fringe benefits, including stock options and other stock related benefits, relocation expenses and imputed income.

For purposes of determining a Participant's Final Average Pay, "Taxable Compensation" shall be computed in the same manner as Compensation, except that salary and all bonuses (without the 50% of base pay limitation) shall be included in Taxable Compensation when paid.

(iii) Compensation Crediting During Disability, Authorized Leave of Absence, or Other Absence. If an Employee who is participating in the Plan is absent from employment due to Disability, an Authorized Leave of Absence (during which time Compensation shall be credited for up to 12 months), or other approved absence for which service credit is given in accordance with Section 2.04(b) (during which time Compensation shall be credited for up to 12 months) (each individually referred to as "Employment Absence"), the Employee shall be deemed to receive Compensation during the period beginning on the date when he incurs an Employment Absence and ending on the earliest of the date on which the Employee's Employment Absence ends, the Employee is deemed to have a Severance from Service, or his Benefit Commencement Date. If the Employee is a FAP Participant, the Employee's Compensation for each month during this period shall equal the amount of Compensation the FAP Participant earned in the month that the FAP Participant incurred the Employment Absence (irrespective of any special compensation the Participant received for that month such as performance-based pay). If the Employee is an AB I or AB II Participant, the Employee's Compensation for each month during this period shall equal one-twelfth of the Employee's annual base rate of pay last in effect for the month in which the Employment Absence occurred. In addition, solely for the month in which the Employment Absence began, Compensation shall include any other Plan Compensation inclusions generally if received in the month the Employment Absence began. For example, if a Participant receives incentive payments during the month in which an Employment Absence began, such amounts shall be included in the Participant's Compensation (if otherwise included in Plan Compensation) in the month received, but shall not otherwise affect the rate of Compensation crediting during the period of Employment Absence.

Notwithstanding the foregoing, with respect to any Disabled FAP Participant qualifying for the special FAP Disability Benefit set forth in Section 7.04(b), the Compensation crediting provisions of this subsection shall not apply and instead the calculation of such Participant's benefit shall be governed by the terms of such Section 7.04(b).

(v) Grandfathered Compensation. Notwithstanding the preceding provisions of this Section 1.16, Compensation and Taxable Compensation shall include all amounts (both deferred and non deferred) payable under the Primary Energy Group Inc. Deferred Compensation Program for calendar year 1999, and 65% of such amounts (both deferred and non deferred) payable under such Program for calendar years commencing on and after January 1, 2000.

(b) Compensation Limit. In addition to other applicable limitations set forth in the Plan, and notwithstanding any other provisions of the Plan to the contrary, the annual Compensation of each Employee taken into account under the Plan shall not exceed the "Compensation Limit." The Compensation Limit for 2014 is $260,000, and is subject to cost of living adjustments in subsequent years in accordance with Code Section 401(a)(17)(B). Any such cost of living adjustment in effect for a calendar year applies to any period, not exceeding 12 months, over which Compensation is determined (the "Determination Period") beginning in such calendar year. If a Determination Period consists of fewer than 12 months, the Compensation Limit will be multiplied by a fraction, the numerator of which is the number of months in the Determination Period, and the denominator of which is 12. If Compensation for any prior Determination Period is taken into account in determining an Employee's benefits accruing in the current Plan Year, the Compensation for that prior Determination Period is subject to the Compensation Limit in effect for that prior Determination Period. Any reference in this Plan to the limitation under Section 401(a)(17) of the Code shall mean the Compensation Limit set forth in this provision. The Compensation Limit and the Determination Period are generally determined on an annual basis in accordance with the foregoing provisions.

(c) Compensation – Special Rules. For purposes of Article XIII (Code Section 415 limits), the Employer shall apply the definition of Compensation set forth 13.06. For purposes of Article XVIII (top heavy) and for determining whether the Plan discriminates in favor of Highly Compensated Employees, the Employer may elect to use an alternate nondiscriminatory definition of Compensation, in accordance with the requirements of Code Section 414(s) and the Treasury Regulations promulgated thereunder. In determining Compensation (for purposes of determining whether the Plan discriminates in favor of Highly Compensated Employees), the Employer may elect to include as Compensation all Elective Contributions (as defined in Code Section 415(c)(3)(D)(i) and (ii)) made by the Employer on behalf of Employees. The Employer's election to include Elective Contributions must be consistent and uniform with respect to Employees and all plans of the Employer for any particular Plan Year. The Employer may make this election to include Elective Contributions for nondiscrimination testing purposes, irrespective of whether Elective Contributions are included in the general definition of Compensation applicable to the Plan.

1.17 Conversion Date. The date on which a Participant transitions from a prior benefit structure under the Plan and begins to accrue an AB II Benefit under Section 4.02 or an AB I Benefit under Section 5.02, as applicable. Notwithstanding the foregoing, as set forth in Schedule II or as provided in a prior restatement for the Plan, during the period a Participant can elect to convert to the AB II Benefit or AB I Benefit, the benefit accrual period for the FAP Benefit (for purposes of calculating the Protected Benefit) may continue through the end of the election period or as otherwise specified. Accordingly, for purposes of calculating the Opening Balance and for crediting Pay-Based Credits and Interest Credits, the Conversion Date is the date the Participant becomes an AB II or AB I Participant (which may be an effective date occurring prior to the end of a cash balance election period). For purposes of calculating the Protected Benefit, the Conversion Date is the date that FAP Benefit accruals cease.

Accordingly, by way of example, but not limited hereto, the following Conversion Dates apply:

(a) In the case of a Participant who elects either the AB I Benefit or the AB II Benefit, as applicable, pursuant to the cash balance election periods described in Schedule II, the Conversion Date shall be as set forth in the applicable subsection of such Schedule.

(b) In the case of a Participant who transfers employment as set forth in Section 3.04 and becomes subject to the AB II Benefit provisions pursuant to the provisions of such Section 3.04, the Conversion Date for purposes of calculating such Participant's Opening Balance shall be the first day of the month coincident with or next following the date of his change in employment status.

(c) In the case of a Participant who terminates employment, is rehired as an Eligible Employee, and who becomes an AB II Participant in accordance with the provision of Section 11.02, the Conversion Date for purposes of calculating the Participant's Opening Balance is the first day of the month coincident with or next following the date of his return to active employment. (Notwithstanding the foregoing, for Exempt Employees rehired prior to May 1, 2007 and terminating prior to January 1, 2011, no Opening Balance was created but instead the FAP Benefit was frozen and paid as part of the Participant's Accrued Benefit.)

(d) In the case of an Exempt Employee participating in the Plan on January 1, 2011, who becomes an AB II Participant pursuant to Section 4.01(a)(iii) and Section 4.08, the Conversion Date is January 1, 2011 (December 31, 2010 for purposes of calculating the Protected Benefit).

(e) In accordance with Section 4.08, in the case of any frozen prior benefit of any active Exempt Employee accruing a benefit under the Plan on or after January 1, 2011, the Conversion Date for any previously accrued frozen FAP Benefit is as follows:

(i) With respect to any active Exempt Employee accruing a benefit under the Plan on January 1, 2011, the Conversion Date is January 1, 2011; or

(ii) With respect to any Participant who becomes an active Exempt Employee accruing a benefit under the Plan after January 1, 2011, the Conversion Date is the date such Participant becomes an active Exempt Employee accruing a benefit under the Plan.

(f) Also in accordance with Section 4.08, in the case of any frozen prior benefit of any active Non-Exempt Employee accruing a benefit under the Plan on or after January 1, 2013, the Conversion Date for any previously accrued frozen FAP Benefit is as follows:

(i) With respect to any active Non-Exempt Employee accruing a benefit under the Plan on January 1, 2013, the Conversion Date is January 1, 2013; or

(ii) With respect to any Participant who becomes an active Non-Exempt Employee accruing a benefit under the Plan after January 1, 2013, the Conversion Date is the date such Participant becomes an active Non-Exempt Employee accruing a benefit under the Plan.

(g) In the case of a Disabled Exempt Employee participating in the Plan on January 1, 2012, who becomes an AB II Participant pursuant to Section 4.01(a)(iii)(D) and Section 4.08, the Conversion Date is January 1, 2012 (December 31, 2011 for purposes of calculating the Protected Benefit).

(h) In the case of a Non-Exempt Employee (including any Disabled Non-Exempt Employee) participating in the Plan on January 1, 2013, who becomes an AB II Participant pursuant to Section 4.01(a)(ii) and Section 4.08, the Conversion Date is January 1, 2013 (December 31, 2012 for purposes of calculating the Protected Benefit).

1.18 Credited Service. "Credited Service" means a period of employment used to determine the amount of a Participant's FAP Benefit, as defined in Section 2.02.

1.19 Disability/Disabled. Any physical or mental condition of an Employee that constitutes a disability under the long-term disability plan maintained by an Employer. A Disability commences when the Employee first qualifies for benefits under the Employer's long-term disability plan and ceases when the Employee no longer qualifies for benefits under such plan.

1.20 Early Retirement Age. A Participant's age prior to Normal Retirement Age when the Participant has attained at least age 55 and completed at least ten years of Credited Service.

1.21 Early Retirement Date. The first day of the month following a Participant's Termination of Service on or after his Early Retirement Age, but before his Normal Retirement Age. Notwithstanding the preceding sentence, the Participant may elect as an Early Retirement Date the first day of any month following a Termination of Service after his Early Retirement Age, but not later than the first day of the month coinciding with or next following his Normal Retirement Age.

1.22 Effective Date. January 1, 2014, the date on which the provisions of this amended and restated Plan become effective, except as otherwise provided herein. The original Effective Date of the Plan was January 1, 1945.

1.23 Eligible Employee. Except as otherwise provided under Section 3.04, any Employee employed by the Employer who is receiving remuneration on a salaried basis (whether an Exempt Employee or a Non-Exempt Employee) and who is not covered by the Union Plan. Effective as of January 1, 2013, Eligible Employee shall include any Former NIFL Employee or Former Kokomo Employee who is actively employed by the

Employer on or after such date. Prior to January 1, 2013, any Former NIFL Employee or Former Kokomo Employee was not considered an Eligible Employee under the Plan because such individual participated under the Subsidiary Plan. Notwithstanding the foregoing, effective January 1, 2010, any former participant in the Subsidiary Plan who was excluded from participating in such plan on or after January 1, 2010 by virtue of being a "highly compensated employee" under such plan is considered an Eligible Employee with respect to the Plan effective as of the date of such exclusion. (The Related Employer of any such highly compensated employee has adopted the Plan with respect to such employee effective January 1, 2010.) In addition, the following individuals are not considered Eligible Employees:

(a) Any Next Gen Employee

(b) an intern;

(c) any "Leased Employee" or any independent contractor (as determined by the Employer pursuant to its established payroll practices), regardless of whether a government agency, court or other entity subsequently determines such individual to be an employee); and

(d) any person employed by a Related Employer which has not adopted this Plan.

1.24 Employee. Any person who, on or after the Effective Date, is receiving remuneration for personal services rendered to an Employer (or any other Related Employer required to be aggregated with the Employer under Code Sections 414(b), (c), (m) or (o)). An Employee shall also include any individual on an Authorized Leave of Absence, and to the extent required by Code Section 414(n), any Leased Employee. Directors acting solely in that capacity shall not be considered an Employee. Moreover, an Employee shall not include an individual providing services to an Employer as an "independent contractor" (e.g., a person (who is not considered to be a Leased Employee) who is engaged as an independent contractor pursuant to a contract or agreement between such person and an Employer which designates him as an independent contractor or otherwise contemplates or implies that he shall function as an independent contractor). Only individuals who are paid as employees from an Employer payroll and treated by an Employer at all times as Employees shall be deemed Employees for purposes of the Plan. No independent contractor shall be treated as an Employee under the Plan during the period he renders services to an Employer as an independent contractor.

If the Employer does not characterize a person as an Employee and the Employer is later required to re-characterize such person's status with the Employer as an Employee, the person will be treated as an Employee under the Plan as of the date of the re-characterization, unless an earlier date is necessary to preserve the tax-qualified status of the Plan. Notwithstanding such general re-characterization, such person shall not be considered an "Eligible Employee" for purposes of Plan participation, except and to the extent necessary to preserve the tax-qualified status of the Plan.

1.25 Employer. The Company, NIPSCO and any other Related Employers that shall ratify and adopt this Plan in a manner satisfactory to, and with the consent of, the Committee; any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. Employers participating in the Plan shall be listed on Schedule 1 (attached hereto for informational purposes only and not formally part of the Plan). Unless otherwise provided by the Committee, an Employer participating in the Plan shall automatically cease to participate in the Plan on the date that such entity is no longer considered a Related Employer of the Company, and any employee of such Employer shall cease to accrue a benefit under the Plan as of such date. The Company and any applicable Related Employer may limit or extend the adoption of the Plan and the Trust Agreement to one or more groups of Employees and/or divisions, locations or operations.

1.26 ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

1.27 Exempt Employee. An Eligible Employee who is classified as an exempt employee under the payroll practices of an Employer.

1.28 FAP Benefit. The portion of a Participant's Accrued Benefit that accrues in accordance with Section 6.02.

1.29 FAP Participant. A Participant who is accruing a FAP Benefit under Article VI.

1.30 Final Average Pay. The result obtained by dividing the smaller of (1) the total Compensation or (2) the total Taxable Compensation, paid to an Employee during a considered period by the number of months for which such Compensation or Taxable Compensation was received. The considered period shall be the 60 consecutive, full or partial, calendar months within the last 120 months of Service that produces the highest result. Periods of Service before and after a break in employment shall be considered consecutive. The considered period for determining total Compensation and total Taxable Compensation do not have to be the same period. Total Compensation during a considered period shall not include total bonuses during such period that exceed 50% of total base pay during such considered period.

If an Employee does not receive Compensation or Taxable Compensation during 60 consecutive calendar months within the last 120-month period identified in the preceding paragraph, Compensation and Taxable Compensation shall be determined over the total number of months of receipt within such 120-month period.

For purposes of determining the 60 consecutive calendar months or the last 120 months of Service, a month in which an Employee earns no Compensation shall be disregarded. The Compensation Limit set forth under Section 1.16(b) shall be applied after determining the 60 consecutive calendar months of highest total Compensation or total Taxable Compensation.

1.31 Former Kokomo Employee. Any person previously employed by Kokomo who had an accrued benefit under the Subsidiary Plan on December 31, 2012 prior to its merger into the Plan effective as of such date and who is not a Union Employee who became covered by the Union Plan on such date. Such term shall refer to both (or either, as the context requires): (1) a former participant in the Subsidiary Plan who continues to have a beneficial interest under the Plan but who is not actively employed nor continuing to accrue a benefit under the Plan; and (2) a former participant in the Subsidiary Plan who continues to be employed as an Eligible Employee under the Plan. Former Kokomo Employees shall generally be governed under the terms of the Plan, except as otherwise noted herein.

1.32 Former NIFL Employee. Any person previously employed by NIFL who had an accrued benefit under the Subsidiary Plan on December 31, 2012 prior to its merger into the Plan effective as of such date and who is not a Union Employee who became covered by the Union Plan on such date. Such term shall refer to both (or either, as the context requires): (1) a former participant in the Subsidiary Plan who continues to have a beneficial interest under the Plan but who is not actively employed nor continuing to accrue a benefit under the Plan; and (2) a former participant in the Subsidiary Plan who continues to be employed as an Eligible Employee under the Plan. Former NIFL Employees shall generally be governed under the terms of the Plan, except as otherwise noted herein.

1.33 Highly Compensated Employee. For a particular Plan Year, any Employee who:

(a) at any time during the Plan Year or the prior Plan Year was a five (5)-percent owner (as defined in Section 416(i)(1) of the Code); or

(b) for the preceding Plan Year:

(i) received more than $115,000 in Compensation from the Employer (or such higher amount as adjusted for the cost of living pursuant to Code Section 414(q)(1)), and

(ii) was in the top twenty percent (20%) of Employees when ranked on the basis of Compensation paid during such Plan Year (excluding Employees described in Code Section 414(q)(5) and applicable regulations).

Highly Compensated Employees also include highly compensated former employees. A highly compensated former employee includes any Employee who has separated from Service (or was deemed to have separated from Service) prior to the current or preceding Plan Year, performs no Service for the Employer during such Plan Year, and was a highly compensated active Employee for either the separation year or any Plan Year ending on or after the Employee's 55th birthday in accordance with the rules for determining Highly Compensated Employee status in effect for that determination year and in accordance with applicable Treasury Regulations and IRS guidance.

1.34 Hour of Service. Each hour for which the Employee is paid or entitled to payment for the performance of duties for the Company or any Related Employer. Hours of Service shall be credited in accordance with Department of Labor Regulation Section 2530.200b-2.

1.35 Interest Credits. The amounts credited to a Participant's AB II Account or AB I Account in accordance with Section 4.05 or Section 5.05 respectively.

1.36 Late Retirement Date. For a Participant who remains or becomes employed as an Employee after his Normal Retirement Date, the first day of the month following his Termination of Service.

1.37 Kokomo. Kokomo Gas and Fuel Company, the entity that was previously a participating employer in the Subsidiary Plan prior to NIFL's merger with NIPSCO on July 11, 2011. Leased Employee. Any person (other than an employee of the Employer) who, pursuant to an agreement between the Employer and the leasing organization, has provided services for the Employer (or for the Employer and related persons determined in accordance with Code Section 414(n)(6)) under the primary direction or control of the Employer on a substantially full-time basis for a period of at least one year. Contributions or benefits provided to a Leased Employee by the leasing organization which are attributable to services performed for the Employer shall be treated as being provided by the Employer.

A Leased Employee shall not be considered an Employee of the Employer if both of the following apply:

(a) Such employee is covered by a money purchase pension plan maintained by the leasing organization and which provides:

(i) A non-integrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), including amounts contributed pursuant to a salary reduction agreement under Code Section 125, 401(k), 402(h) or 403(b);

(ii) Immediate participation; and

(iii) Full and immediate vesting.

(b) Leased Employees do not constitute more than twenty percent (20%) of the Employer's non-highly compensated workforce.

1.39 Maximum Primary Social Security Benefit. A term used in determining a supplemental benefit as provided in Sections 5.06, 6.03, or 7.04(b), as applicable, and meaning the monthly amount available to a Participant at normal retirement age under the provisions of Title II of the Social Security Act ("Social Security Retirement Age") in effect at the time of his Termination of Service, assuming the following:

(a) The Participant attained the Social Security Retirement Age in the year of his retirement,

(b) The Participant earned maximum taxable wages under Code Section 3121(a)(1) in all years prior to the year of his retirement, and

(c) The Participant earned maximum taxable wages under Code Section 3121(a)(1) in the year of retirement, if retirement occurs on or after June 1 of the calendar year of retirement.

In no event shall the Maximum Primary Social Security Benefit determined for any Participant be less than the Maximum Primary Social Security Benefit that would have been determined for a Participant had his employment terminated at an earlier date

1.40 Next Gen Employee. Any Employee who participates in the "Next Gen" benefit structure offered by the Employer or a Related Employer and accordingly does not participate in the Plan (*i.e.*, does not accrue new or additional benefits under the Plan, other than Interest Credits, if applicable) or other defined benefit pension plan of a Related Employer. Such Next Gen Employee shall include (1) any Exempt Employee who is hired or rehired on or after January 1, 2010 and (2) any Non-Exempt Employee who is hired or rehired on or after January 1, 2013. In addition, in accordance with Section 3.04(e), Next Gen Employee also shall refer to any Exempt or Non-Exempt Employee who transfers job positions (within the Employer or with a Related Employer) and who becomes or remains a Next Gen Employee after the transfer.

1.41 NIFL. Northern Indiana Fuel and Light Company Inc., the entity that was previously a participating employer in the Subsidiary Plan prior to NIFL's merger with NIPSCO on July 11, 2011.

1.42 NIPSCO. Northern Indiana Public Service Company, a wholly-owned subsidiary of the Company.

1.43 NiSource. NiSource Inc., a Delaware corporation, or any successor to it in the ownership of substantially all its assets. NiSource is the "Company" for purposes of this Plan and is the parent company of NIPSCO which also participates in and sponsors the Plan.

1.44 Non-Exempt Employee. An Eligible Employee who is classified as a non-exempt employee under the payroll practices of an Employer.

1.45 Normal Retirement Age. The later of: (a) the Participant's 65th birthday; or (b) the fifth anniversary of the date on which the Participant commenced participation in the Plan.

1.46 Normal Retirement Date. The first day of the month next following the Participant's Normal Retirement Age.

1.47 Opening Balance. The initial bookkeeping account established for a Participant's AB II Account or for a Participant's AB I Account, as provided in Section 4.03 or Section 5.03, respectively.

1.48 Participant. An Eligible Employee who has become a Participant under Article III. With respect to any action that may be taken by a Participant under the Plan, Participant shall include any person or entity appointed to represent a Participant under a validly executed Power of Attorney.

A Participant generally shall be exclusively at any given time an AB II Participant, AB I Participant or FAP Participant. Notwithstanding the foregoing, in the case of a FAP Participant who elects to become an AB II Participant or AB I Participant pursuant to an election period window, the Participant shall be treated as both a FAP Participant and an AB I Participant during the election period provided.

1.49 Pay-Based Credits. Additions to a Participant's Account determined pursuant to Sections 4.04 and 5.04 of the Plan.

1.50 Plan. The plan designated the NiSource Salaried Pension Plan (formerly known as the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Salaried and Non-Exempt Employees), as set forth herein or in any amendments hereto.

1.51 Plan 2006 Restatement. The Plan document as amended and restated effective January 1, 2006.

1.52 Plan Administrator. The Committee, or such delegate of the Committee designated to carry out the administrative functions of the Plan.

1.53 Plan Sponsor. The Company is designated the sponsor of the Plan.

1.54 Plan Year. The calendar year.

1.55 Point Service. A period of employment used to determine the amount of Pay-Based Credits that are credited to a Participant's AB II Account or AB I Account, as defined in Section 2.03.

1.56 Protected Benefit. The benefit described under Section 4.07 and Section 5.07, as applicable.

1.57 Related Employer. The Company and any other entity which is related to the Company as a member of a controlled group of corporations in accordance with Code Section 414(b), or as a trade or business under common control in accordance with Code Section 414(c), or any organization which is part of an affiliated service group in accordance with Code Section 414(m), or any entity required to be aggregated with the Company in accordance with Code Section 414(o) and the regulations thereunder. If the Employer is a member of a group of Related Employers, the term "Employer" includes the Related Employers for purposes of determining Hours of Service and Years of Eligibility Service, Vesting Service and Credited Service, applying the participation test of Code Section 401(a)(26) and the coverage test of Code Section 410(b), applying the limitations of Article XIII, applying the Top Heavy rules and the minimum benefit requirements of Article XVIII, the definitions of Employee, Highly Compensated Employee, Compensation and Leased Employee contained in this Article I, and for any other purpose as required by the Code or by the Plan. However, only a Related Employer which has adopted the Plan may participate therein, and unless specifically provided otherwise, only service during a period of employment while so participating shall count as Credited Service or Point Service hereunder. For the purposes under the Plan of determining whether or not a person is an Employee and the period of employment of such person, each such other company shall be included as a Related Employer only for such period or periods during which such other company is a member of a controlled group, under common control, an affiliated service group or otherwise required to be aggregated with the Employer.

1.58 Severance from Service. An absence from employment, as defined in Section 2.05.

1.59 Single Life Annuity. An annuity providing monthly payments for the lifetime of the Participant with no survivor benefits.

1.60 Social Security Retirement Age. The age used as the full retirement age for the Participant under Section 216(l) of the Social Security Act as if the early retirement age under Section 216(l)(2) of such Act was age 62.

1.61 Spouse. The spouse of the Participant as recognized under the laws of the State in which the Participant resides. Notwithstanding the foregoing, effective September 16, 2013, the term "Spouse" shall include any individual who is lawfully married to a Participant under any State law, including individuals married to Participants of the same sex who were legally married in a State that recognizes such marriages, but who are domiciled in a State that does not recognize such marriages. For purposes of the foregoing sentence, "State" shall mean any domestic or foreign jurisdiction having legal authority to sanction marriages (*i.e.*, any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, any other territory or possession of the United States, and any foreign jurisdiction having the legal authority to sanction marriages).

1.62 Subsidiary Plan. The NiSource Subsidiary Pension Plan, which was originally effective January 1, 1962 and which was merged into the NiSource Pension Plan on December 31, 2012.

1.63 Taxable Wage Base. The taxable wage base for old-age, survivors, and disability insurance as determined under Section 230 of the Social Security Act.

1.64 Termination of Service. The last date on which an individual performs duties as an Employee of the Company or Related Employer, or any other date determined in accordance with the Company's policies and practices.

1.65 Treasury Regulations. Regulations promulgated under the Internal Revenue Code by the Secretary of the Treasury.

1.66 Trust. The trust fund maintained in accordance with Article XVII from which benefits provided under the Plan will be paid.

1.67 Trust Agreement. The agreement establishing and maintaining the Trust, as provided for in Article XVII, as the same may be amended from time to time.

1.68 Trustee. The individual(s) and/or entity or entities appointed to administer and maintain the Trust in accordance with Article XVII.

1.69 Union Employee. An Employee covered by a collective bargaining agreement with the Employer.

1.70 Union Plan. The NIPSCO Union Pension Plan (formerly known as the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining To Bargaining Unit Employees).

1.71 Vested/Nonforfeitable. A Participant's or Beneficiary's unconditional claim, legally enforceable against the Plan, to all or a portion of the Participant's Accrued Benefit.

1.72 Vesting Service. A period of employment used to determine a Participant's eligibility to receive benefits, as defined in Section 2.01.

1.73 Terms Defined Elsewhere:

Annual Benefit ..... Section 13.06
Compensation (Top Heavy) ..... Section 18.03
Compensation (Section 415) ..... Section 13.06
Deferred Vested Benefit ..... Section 8.01

Defined Benefit Compensation Limitation ..... Section 13.06
Defined Benefit Dollar Limitation ..... Section 13.06
Determination Date (Top Heavy) ..... Section 18.03
Direct Rollover ..... Section 10.10
Distributee ..... Section 10.10
Early Retirement Benefit ..... Section 7.03
Elective Transfer ..... Section 20.04
Eligible Retirement Plan ..... Section 10.10
Eligible Rollover Distribution ..... Section 10.10
Employer (Top Heavy) ..... Section 18.03
Employer (Section 415) ..... Section 13.06
FAP Disability Benefit ..... Section 7.04
Investment Managers ..... Section 16.04
Key Employee ..... Section 18.03
Kokomo Prior Plan ..... Section 6.02
Limitation Year ..... Section 13.06
Maximum Permissible Benefit ..... Section 13.06
NIFL Prior Plan ..... Section 6.02
Non-Key Employee ..... Section 18.03
Nontransferable Annuity ..... Section 10.08
Normal Retirement Benefit ..... Section 7.01
Permissive Aggregation Group ..... Section 18.03
Preretirement Survivor Annuity ..... Section 9.02
QDRO ..... Section 10.09
Qualified Joint and Survivor Annuity (QJSA) ..... Section 10.01
Required Aggregation Group ..... Section 18.03
Retroactive Annuity Starting Date ..... Section 10.12
Top Heavy ..... Section 18.02
Vested Retirement Date ..... Section 8.01
Year of Service (Section 415) ..... Section 13.06

ARTICLE II

SERVICE PROVISIONS

2.01 Vesting Service. "Vesting Service" means the period of employment with the Company or a Related Employer used to determine a Participant's eligibility to receive benefits. Vesting Service is also used to determine if an Employee's Vesting Service, Credited Service, and Point Service prior to a Break in Service shall be reinstated if the Employee is reemployed.

(a) In General. Except as otherwise provided in this Section and subject to Section 2.04, an Employee shall receive credit for Vesting Service for the period beginning on the first day on which the Employee performs an Hour of Service and ending on the Employee's Severance from Service. Vesting Service shall be determined in completed years and days, with each 365 days constituting one year.

(b) Disability. An Employee shall continue to earn Vesting Service while he is Disabled and receiving a benefit under the long-term disability plan maintained by the Employer.

(c) Leased Employees. If a Leased Employee becomes eligible to participate in the Plan as a result of later employment with an Employer, the Leased Employee shall receive credit for Vesting Service as a Leased Employee.

2.02 Credited Service. "Credited Service" means the period of employment used to determine the amount of a Participant's FAP Benefit. Credited Service is also used to determine whether a Participant is entitled to commence distribution of his FAP Benefit before his Normal Retirement Date.

(a) In General. Except as otherwise provided in this Section and subject to Section 2.04, a Participant shall receive credit for Credited Service for the period beginning on the first day of the month that includes the first day on which the Participant performs an Hour of Service and ending on the Participant's Severance from Service. Credited Service shall be determined in completed years and months, with a month of Credited Service being credited for any month in which the Participant has at least one Hour of Service. (For benefit determinations prior to January 14, 2010, Credited Service includes only a fractional month in the month of hire and the month of termination of employment based on the number of days employed in each such month.)

(b) Excluded Periods. Notwithstanding subsection (a), a Participant's Credited Service shall not include the following periods:

(i) the period following the Participant's Conversion Date (if any), provided that this provision shall not apply in the case of a Participant who again becomes a FAP Participant following a Conversion Date; or

(ii) any period during which the Participant is in a position of employment either–

(A) as an Employee of an Employer where he does not meet the requirements to be a Participant; or

(B) as an Employee of a Related Employer that is not an Employer, except as otherwise provided in the Plan, such as in the Plan transfer provisions of Section 3.04.

(c) Disability. In the case of a Participant who has a Disability, provided the Participant is not receiving the FAP Disability Benefit described in 7.04, the Participant shall continue to earn Credited Service while he is Disabled and receiving a benefit under the long-term disability plan maintained by the Employer.

2.03 Point Service. "Point Service" means the period used to determine the amount of Pay-Based Credits that are credited to a Participant's AB I Account or AB II Account.

(a) In General. Except as otherwise provided in this Section and subject to Section 2.04, a Participant shall receive credit for Point Service for the period beginning on the first day of the month that includes the first day on which the Participant performs an Hour of Service and ending on the last day of the year in which the Participant's Termination of Service occurs. Notwithstanding the preceding sentence, Point Service for the year in which the Participant first performs an Hour of Service shall be determined in completed months, with a month of Point Service being credited for any month in which the Participant has at least one Hour of Service.

(b) Excluded Period. Notwithstanding subsection (a), a Participant's Point Service shall not include any period during which the Participant is in a position of employment as an Employee of an Employer where he does not meet the requirements to be a Participant.

(c) Disability. In the case of a Participant who has a Disability, the Participant shall continue to earn Point Service while the Disability continues (regardless of whether the absence from employment due to the Disability lasts beyond one year and thus could constitute a "Severance from Service").

Point Service shall cease to be credited pursuant to this subsection as of the earliest of (1) the date on which the Participant's Disability ends (which shall be deemed the Participant's Termination of Service unless returning to employment with the Company or Related Employer or unless the Employer determines a different Termination of Service date); (2) the date on which the Participant returns to employment with the Company or a Related Employer; or (3) the Participant's Benefit Commencement Date.

(d) Service with Related Employers. Point Service shall include any period during which an Employee is employed by an Employer or a Related Employer.

(e) Benefit Conversion. Notwithstanding subsection (a), in the case of a FAP Participant who elected to become an AB II Participant or AB I Participant pursuant to an election described in Schedule II, Point Service prior to the Participant's conversion to the AB II Benefit or AB I Benefit shall be equal to the amount of Credited Service (as determined under Section 2.02) the Participant earned prior to the Conversion Date.

2.04 Special Service Rules.

(a) Rehired Employees.

(i) In General. Subject to subsections (ii) and (iii) below, an Employee who is rehired after having a Severance from Service shall have his Vesting Service, Credited Service, and Point Service reinstated upon reemployment as follows:

(A) If the Employee is reemployed before a Break in Service occurs, the Employee's complete and partial years of such service shall be reinstated upon reemployment. In addition, if the Employee is reemployed within one year after a Severance from

Service that results from quit, discharge, or retirement, the Employee shall receive credit for such service for the period between the Employee's Severance from Service and reemployment.

(B) If the Employee is reemployed after a Break in Service occurs, the Employee shall not receive credit for service for the period between the Employee's Severance from Service and the Employee's reemployment. The Employee's complete and partial years of service earned prior to the Break in Service shall be reinstated only if–

1. the Employee was vested in any part of his benefits under the Plan prior to the Severance from Service; or

2. the number of consecutive Break in Service periods does not equal or exceed the greater of five years or the number of years of Vesting Service completed prior to the Break in Service. For purposes of this subparagraph, the number of years of Vesting Service completed prior to a Break in Service shall not include years of Vesting Service disregarded by reason of any prior Break in Service.

Notwithstanding the foregoing, an Employee's Credited Service and Point Service shall not be reinstated upon reemployment if the Employee has received a lump sum distribution of his retirement benefit after the earlier Termination of Service, except as otherwise provided in Section 11.02(b)(iii).

(ii) Next Gen Employees. With respect to any Employee who is rehired as a Next Gen Employee, the service reinstatement provisions set forth in subsection (i) shall only apply with respect to Vesting Service. Such rehired Next Gen Employee shall not receive reinstatement of or additional credit of Credited Service and Point Service.

(iii) Special Service Crediting for Prior Terminations. With respect to Participants both in the Plan prior to January 1, 1985and having a Termination of Service before such date, the following special provisions shall apply:

(A) Upon reemployment of a nonvested Eligible Employee whose Termination of Service occurred before January 1, 1976, such Employee shall be treated as a new Eligible Employee for all purposes of the Plan.

(B) Upon reemployment of a nonvested Eligible Employee whose Termination of Service occurred on or after January 1, 1976 but prior to January 1, 1985, such Employee shall receive credit for service earned prior to the Termination of Service.

(b) Authorized Leaves and Other Absences. Subject to subsections (d) and (e) below, an Employee's Vesting Service, Credited Service, and Point Service shall include any period of an Authorized Leave of Absence up to 12 months. Vesting Service, Credited Service, and Point Service shall also include periods of absences for such other reasons and within such time limitations as may be approved by the Committee for general application to all Employees.

(c) Acquired Businesses. If an individual becomes an Employee upon the acquisition of all or a portion of the business of his former employer by the Company or a Related Employer, whether by merger, acquisition of assets or stock, or otherwise, his service with the predecessor employer shall be

included in determining his Vesting Service, Credited Service, and Point Service if, and to the extent that, this service is required to be credited by–

(i) Code Section 414(a);

(ii) the terms of the agreement under which the Company or Related Employer acquired the business of the former employer; or

(iii) a specific approval by the Committee.

Notwithstanding the foregoing, any such agreement or Committee action may provide that the prior period of employment shall be taken into account only when determining the Employee's Vesting Service, Credited Service, or Point Service, or any combination of these types of service.

(d) Military Service. Notwithstanding any provision of the Plan to the contrary, effective December 12, 1994, contributions, benefits and service credits with respect to qualified military service shall be provided in accordance with Code Section 414(u).

(e) Family and Medical Leave. Notwithstanding any provision of the Plan to the contrary, any Participant on leave under the Family and Medical Leave Act shall receive contributions, benefits and service credits in accordance with such Act.

(f) Crediting for Specific Groups.

(i) NiSource Inc. Organizational Restructuring. Notwithstanding the provisions contained elsewhere in the Plan, the provisions of this subsection (f)(i) shall be applicable to each Participant who (1) is notified of his involuntary separation under the NiSource Inc. Organizational Restructuring between August 28, 2002 and December 31, 2002, and (2) signs the release attached to his severance agreement, in accordance with the procedures set forth therein, or if appropriate, any subsequently tendered release from the Company.

Each Participant who satisfies both of the requirements in the preceding paragraph shall have the length of the period related to his severance benefits count toward meeting the age and service requirements applicable to eligibility for an Early Retirement Benefit or a Deferred Vested Benefit under the Plan. Notwithstanding the preceding sentence, the Participant shall not be allowed to commence payment of his Early Retirement Benefit or Deferred Vested Benefit prior to the date on which he actually attains the commencement age required by Sections 7.03 or 8.01 of the Plan. In no event shall the length of the period related to a Participant's severance benefits count for purposes of Credited Service or Point Service in calculating the amount of an annuity benefit payable to such Participant.

(ii) IBM (Periods 1996-2001). In the calculation of Vesting Service, Credited Service (for purposes of determining the Early Retirement Benefit, the benefit supplements, eligibility for the FAP Disability Benefit), and Point Service, the Plan shall include any period between January 1996 and May 2001 during which an Employee, who immediately prior to January 1996 was an employee of Northern Indiana Public Service Company, provided information technology services to Northern Indiana Public Service Company while an employee of International Business Machines Corporation ("IBM").

(iii) IBM (2005). While the Vesting Service provisions set forth in this Article II continue to apply, with respect to any Participant who (1) was notified in writing on June 21, 2005 or any

following date up to and including December 31, 2005, that his employment was outsourced to the International Business Machines Corporation ("IBM"), or (2) received an initial Severance Letter Agreement dated June 21, 2005, or any following date up to and including December 31, 2005, from NiSource in connection with NiSource's outsourcing agreement with IBM, then such Participant shall be subject to a 3-year cliff Vesting provision as set forth in Section 8.02, effective as of such outsourcing date(s). In addition, any such Participant shall be credited with up to a total of 3 years of additional age and/or Credited Service in order to allow the Participant to be entitled to the age 55 and 25 years of Credited Service percent of reduction described in Section 7.03(b).

(iv) The Wood Group (2007). In accordance with the acquisition provisions set forth in subsection (c) above, for purposes of the calculation of an Eligible Employee's Vesting Service and Point Service, the Plan shall include any service that such Employee previously performed as an employee of the Wood Group, an employee leasing company that was providing personnel to Broadway Gen Funding, LLC which was acquired by the Company pursuant to an agreement signed on or about November 2, 2007.

2.05 Severance from Service. "Severance from Service" means the earlier of subsection (a) or (b) below:

(a) the date the Employee quits, retires, is discharged, or dies; or

(b) the first anniversary of the first day of an Employee's absence from employment with the Company or a Related Employer (with or without pay) for any reason other than in (a) above, such as vacation, sickness, leave of absence, layoff, or military service (except as otherwise provided for Disabled Employees and in Section 2.04). Notwithstanding the foregoing, in no event shall an Employee have a Severance from Service solely as a result of taking an authorized leave of absence pursuant to the Family and Medical Leave Act of 1993.

An Employee who fails to return to employment at the expiration of an absence shall be deemed to have had a Severance from Service on the earlier of the expiration of the Employee's absence or the first anniversary of the first day of the Employee's absence.

2.06 Break in Service. "Break in Service" means each 12 consecutive month period beginning on the date an Employee incurs a Severance from Service and ending on the anniversary of that date, provided that the Employee does not perform an Hour of Service during that period.

Solely for purposes of determining whether a Break in Service has occurred, if an Employee is absent from work beyond the first anniversary of the first date of an absence and the absence is for maternity or paternity reasons, the date the Employee incurs a Break in Service shall be the second anniversary of the Employee's absence from employment. The period between the first and second anniversary of the first date of absence shall not constitute service. For purposes of this section, an absence from work for maternity or paternity reasons means an absence by reason of (1) the Employee's pregnancy, (2) the birth of the Employee's child, (3) the placement of a child with the Employee in connection with the adoption of the child, or (4) the caring for a child for a period immediately following the child's birth or placement.

ARTICLE III

PARTICIPATION AND TRANSFERS

3.01 Date of Participation. An Eligible Employee shall participate in the Plan as follows:

(a) An Eligible Employee who was a Participant in the Plan on the day before the Effective Date of this restated Plan shall continue as a Participant in this Plan as restated.

(b) Immediate Participation. Any other Eligible Employee shall become a Participant on the date on which he first performs an Hour of Service as an Eligible Employee.

(c) Previous Provision. Prior to May 1, 2007, an Eligible Employee (other than a part-time Eligible Employee regularly scheduled to work fewer than 40 hours per week) became a Participant as of the expiration of the first 12-month period in which he completed an hour of employment. Effective May 1, 2007, with respect to any Eligible Employee hired on or after May 1, 2006 (other than a part-time Eligible Employee regularly scheduled to work fewer than 40 hours per week), such Eligible Employee became a Participant on May 1, 2007. Notwithstanding the foregoing, for purposes of accruing Pay-Based Credits under Article V for Plan Years prior to 2004, once an Eligible Employee becomes a Participant pursuant to this Section, Pay-Based Credits shall be calculated from the date the Eligible Employee first performs an Hour of Service (rather than from the date of Plan participation).

(d) The Plan Administrator shall determine the eligibility of each Employee to participate in the Plan for each Plan Year based on information furnished by the Employer. Such determination shall be within the discretion of the Plan Administrator and shall be conclusive and binding upon all persons as long as such determination is made pursuant to the Plan and ERISA.

In accordance with the definition of "Eligible Employee" set forth in the Plan, Next Gen Employees are not eligible to participate in (*i.e.*, cannot accrue new or additional benefits under) the Plan.

Notwithstanding the foregoing, Former NIFL Employees and Former Kokomo Employees became Participants in the Plan on January 1, 2013 in conjunction with the merger of the Subsidiary Plan with and into the Plan. The provisions governing Former NIFL Employees' and Former Kokomo Employees' previous participation in the Subsidiary Plan are described as applicable in this document. To the extent not herein described (or with respect to such non-active (terminated vested) Participants), the terms of previous participation in the Subsidiary Plan by Former NIFL Employees or Former Kokomo Employees are determined by reference to the Subsidiary Plan in effect prior to the merger of that plan into the Plan.

3.02 Participation Upon Reemployment. If a former Eligible Employee again becomes an Employee after a Severance from Service, such Employee shall be considered a Next Gen Employee and no longer eligible to actively participate in the Plan (*i.e.*, cannot accrue new or additional benefits under the Plan, other than Interest Credits, if applicable).

3.03 Continuation of Participation. A Participant shall continue to be a Participant as long as he has an undistributed beneficial interest in the Plan. In accordance with Article VIII, if upon Termination of Service a Participant's Vested Accrued Benefit is zero, the Participant shall be deemed to have received an immediate lump sum payment of his benefit and shall thereupon cease to be a Participant.

3.04 Transfers. Unless otherwise indicated, the provisions of this Section 3.04 shall be effective for transfers occurring on or after January 1, 2013. Transfers occurring prior to such date shall be governed by the provisions as set forth in the Plan 2011 Restatement.

(a) Transfers from Related Employers or Between Plans. Notwithstanding any provision to the contrary contained in the Plan, and subject to the exception set forth in subsection (e) below, the provisions of this subsection (a) shall govern the benefit accrual of any Employee who transfers to employment otherwise providing coverage under the Plan and who on the date of transfer: (i) was covered under a Related Employer's defined benefit plan; or (ii) transfers within the same Employer but was covered under a different defined benefit plan. The treatment of such Employee's benefit accrual shall depend on the nature of the position (i.e., Exempt or Non-Exempt, union or non-union) from and to which the Employee transfers, and in instances set forth in subsection (e), the date of hire of such Employee, as set forth below.

(i) If transferring from a non-union position (either as an exempt or non-exempt employee) covered under the Related Employer's plan (or a different pension plan of the Employer) to employment as a non-union Employee (either an Exempt or a Non-Exempt Employee), then such Employee shall continue to accrue a benefit under such Related Employer's plan (or Employer's other plan) and shall accrue no benefit under the Plan from and after the date of transfer. In accordance with the terms of the Related Employer's plan (or the Employer's other plan), the transferred Employee shall remain subject to the benefit accrual method in effect for the Employee prior to the transfer.

(ii) Except as provided in subsection (iii) below, if transferring from a union position covered under a Related Employer's plan to employment as an Exempt Employee or as a Non-Exempt Employee, then such Employee shall cease to accrue a benefit in such Related Employer's plan as of the date of transfer and shall begin to participate in the Plan as a new AB II Participant on the date of such transfer. Such Participant shall receive a $0 Opening Balance and shall have Vesting Service and Point Service under the Plan calculated to include service earned under the Related Employer's plan prior to the transfer. For purposes of the benefit accrued under the Related Employer's plan (e.g., for calculating the frozen benefit under the Related Employer's plan), "Credited Service" under the Related Employer's plan shall cease to accrue as of the date of transfer, except that the Participant's service with the Employer or any Related Employer shall also be counted as "Credited Service" under the plan with the frozen benefit solely for purposes of determining eligibility for the "Early Retirement Benefit" under such plan (but for no other purpose).

(iii) If transferring from a union position covered under the Union Plan to employment as an Exempt or Non-Exempt Employee, then such Employee shall cease to accrue a benefit under the Union Plan as of the date of transfer and shall begin to participate as an AB II Benefit Participant in the Plan. Upon the expiration of a one-year period from the date of transfer (or if earlier, upon the retirement of the transferred Employee), such transferred Employee's accrued benefit in the Union Plan shall be converted to an Opening Balance under the AB II Benefit of the Plan as provided in Section 4.03(b) of the Plan. Notwithstanding the foregoing, if an Employee transfers from a union position covered under the Union Plan to employment covered under the Plan and back to a union position covered under the Union Plan as applicable, within a one-year period, he shall be considered as participating in the Union Plan for the entire period and shall not be considered as participating in the Plan for any period. Provided the foregoing one-year period is satisfied (or if earlier, upon the retirement of the transferred Employee), all service both before and after the date of transfer shall be included in the Employee's Vesting Service and Point Service under the Plan. For purposes of the

benefit accrued under the Union Plan (e.g., for calculating the Protected Benefit from such plan), "Credited Service" under the Union Plan shall cease to accrue as of the date of transfer.

(b) Transfers to Related Employers or Between Plans. Notwithstanding any provision to the contrary contained in the Plan, and subject to the exception set forth in subsection (e) below, the provisions of this subsection (b) shall govern the benefit accrual of any Employee who transfers from employment that provides for coverage under the Plan to (i) employment with a Related Employer that has not adopted the Plan as of the date of transfer; or (ii) employment with the same Employer, but in an employment category that is covered under a different pension plan. The treatment of such Employee's benefit accrual shall depend on the nature of the position (i.e., Exempt or Non-Exempt, union or non-union) from and to which the Employee transfers as set forth below.

(i) If transferring from a non-union position (either as an Exempt Employee or a Non-Exempt Employee) covered under the Plan to a non-union position of a Related Employer that has not adopted the Plan, then such Employee shall continue to accrue a benefit under the Plan and shall accrue no benefit under the Related Employer's defined benefit plan (if any) from and after the date of transfer. Such Employee shall continue to be considered an Employee in the Plan, and shall continue to earn Point Service under the Plan from and after the date of transfer until the date of his Termination of Service.

(ii) Except as provided in subsection (iii) below, if transferring from any position covered under the Plan (an Exempt Employee or a Non-Exempt Employee) to employment in a union position of a Related Employer that has not adopted the Plan, the Accrued Benefit of the Employee in the Plan shall be frozen as of the date of his transfer and such Employee shall begin to participate in the Related Employer's defined benefit plan (if any) as a new "AB II Benefit" employee, if applicable, on the date of such transfer. If the AB II Benefit structure is not offered in the Related Employer's plan, such plan's "AB I Benefit" structure or "FAP Benefit" structure, as applicable, shall apply. If either the AB II Benefit or AB I Benefit structure applies, all service both before and after the date of transfer shall be included in the Employee's vesting service and point service under such Related Employer's plan. If the FAP Benefit structure applies, only service after the date of transfer shall be included for purposes of benefit accrual under the Related Employer's plan. For purposes of the Employee's frozen benefit under the Plan, such Employee shall cease to earn Pay-Based Credits as of the date of such transfer, unless he again transfers to employment providing coverage under the Plan, but shall continue to earn Interest Credits until the date his pension commences.

(iii) If transferring from any position covered under the Plan (an Exempt Employee or a Non-Exempt Employee) to employment in a union position covered under the Union Plan, the Accrued Benefit of the Employee in the Plan shall be converted to an Opening Balance under the "AB I Benefit" option of the Union Plan. All service both before and after the date of transfer shall be included in the Employee's vesting service and point service under Union Plan. For purposes of the benefit accrued under the Plan (e.g., for calculating the Protected Benefit transferred from the Plan to the Union Plan), "Credited Service" under the Plan shall cease to accrue as of the date of transfer.

(c) Transfers within the Plan. Notwithstanding any provision to the contrary contained in the Plan, and subject to the exception set forth in subsection (e) below, any Employee who transfers between employment positions that are both covered under the Plan (*e.g.*, Non-Exempt Employee to Exempt Employee (or vice versa)) shall continue to participate in the Plan as an AB II Benefit Participant after such transfer.

(d) Transfer from Disabled to Active Status. For any Participant who returns to active work immediately after a Disability, such Participant shall continue to have his accruals after returning to active work status determined under the AB II Benefit provisions of Article IV of the Plan. Notwithstanding the foregoing, similar to the exception described in subsection (e) below, if a Disabled Participant returns to active work on or after January 1, 2013, such Participant shall continue to accrue benefits under the Plan (which shall be under the AB II Benefit provisions) provided that the Participant, prior to the occurrence of the Disability, was hired or rehired prior to the date the Next Gen Employee benefit paradigm was implemented (*i.e.*, hired/rehired prior to January 1, 2010 if returning to active employment as an Exempt Employee; or hired/rehired prior to January 1, 2013 if returning to active employment as a Non-Exempt Employee; or not otherwise hired/rehired as a Next Gen Employee).

Prior to January 1, 2009, a Participant who returned to active work after a Disability was entitled to make a cash balance election in accordance with the provisions of Schedule II (5).

(e) Next Gen Employee Transfers. In accordance with the definition of "Eligible Employee" and the participation provisions of Section 3.01, Employees who are classified as Next Gen Employees are not eligible to accrue new or additional benefits under the Plan. The transfer provisions set forth in this Section 3.04 shall be modified for any Next Gen Employee as follows:

(i) Transfer of Employees Hired/Rehired Prior to January 1, 2010. The transfer provisions of this Section 3.04 shall continue to apply to any Employee who was hired or rehired prior to January 1, 2010. Such an Employee is not considered a Next Gen Employee (unless he or she terminates employment and is rehired as a Next Gen Employee).

(ii) Transfer of Employee Hired/Rehired On or Between January 1, 2010 and December 31, 2012. With respect to an Employee who is hired or rehired on or between January 1, 2010 and December 31, 2012, the treatment of such Employee's benefit accrual (or status as a Next Gen Employee) upon a transfer shall depend on the nature of the position (*i.e.*, Exempt or Non-Exempt, union or non-union) from and to which the Employee transfers as set forth below.

(A) Transfer From Exempt or Non-Exempt to Exempt Employee Status. Any Exempt Employee who is hired or rehired on or after January 1, 2010 is a Next Gen Employee and not eligible to accrue benefits under the Plan. Similarly, any Employee hired/rehired on or between January 1, 2010 and December 31, 2012 (whether Exempt or Non-Exempt) who transfers to an "Exempt Employee" position with the Employer (or a Related Employer) shall remain or become a Next Gen Employee on the date of such transfer and shall accrue no additional benefit under the Plan (or the plan of a Related Employer, in the case of transfers to a Related Employer).

(B) Transfer From Exempt to Non-Exempt Employee Status. Similar to subsection (ii)(A) above, any Next Gen Employee who transfers from an "Exempt Employee" position with the Employer (or a Related Employer) to a Non-Exempt position with the Employer (or a Related Employer) shall remain a Next Gen Employee and shall not participate in the Plan (or the plan of a Related Employer). However, if such Next Gen Employee transfers to a union position that does not offer the Next Gen benefit structure, then such employee will participate in the benefit structure offered pursuant to the applicable collective bargaining agreement.

(C) Transfer from Non-Exempt Employee to Non-Exempt Employee Status. Subject to the exception set forth in this subsection (C) for certain union employees of Related Employers, any Non-Exempt Employee hired/rehired on or between January 1, 2010

and December 31, 2012 who transfers to a different Non-Exempt Employee position is not considered a Next Gen Employee (unless he/she terminates employment and is rehired on or after January 1, 2013). Accordingly, the transfer provisions of this Section 3.04 generally shall continue to apply. Notwithstanding the foregoing, with respect to any union employee of a Related Employer who is considered a "Next Gen Employee" by such Related Employer (due to being hired or rehired on or after implementation of Next Gen provisions effective January 1, 2011), such employee shall remain a Next Gen Employee upon transfer and shall not participate in the Plan.

(iii) Transfer of Employee Hired/Rehired On or After January 1, 2013. Subject to the exception set forth in the next sentence, any Next Gen Employee (who is classified as such because hired or rehired on or after January 1, 2013) shall remain a Next Gen Employee upon the transfer to or from the Employer (or a Related Employer) and shall not participate in the Plan (or the plan of a Related Employer). Notwithstanding the foregoing, if such Next Gen Employee transfers to a union position that does not offer the Next Gen benefit structure, then such employee will participate in the benefit structure offered pursuant to the applicable collective bargaining agreement.

(f) Impact of Plan Conversion for Any Frozen Prior Benefit. Notwithstanding any other provision in this Section 3.04, any who transfers positions to become an AB II Participant (in accordance with the transfer provisions of the Plan) shall be subject to Section 4.08 of this Plan and the analogous section of an applicable other defined benefit plan of the Employer or Related Employer.

3.05 Conditions of Participation.

Participation in this Plan by any Eligible Employee shall be contingent upon receipt by the Plan Administrator of such applications, consents, proofs of birth, elections, beneficiary designations and other documents and information as prescribed by the Plan Administrator. Each Employee, upon becoming a Participant, shall be deemed conclusively and for all purposes to have assented to the terms and provisions of this Plan and shall be bound thereby.

ARTICLE IV

AB II BENEFIT

4.01 Applicability of Article. This Article IV sets forth the method for determining the ongoing benefit accrual under the Plan on or after the Effective Date for any Participant who is an Eligible Employee on or after the Effective Date.

(a) Participants Entitled to AB II Benefit. The provisions of this Article shall apply in determining the Accrued Benefit for any Participant described as follows:

(i) any Non-Exempt Employee hired or rehired on or after January 1, 2008 but before January 1, 2013;

(ii) all Non-Exempt Employees who are participating in the Plan on and after January 1, 2013 (including all Non-Exempt Employees on Disability as of January 1, 2013);

(iii) all Exempt Employees who are participating in the Plan on and after January 1, 2011, including;

(A) any Exempt Employee (other than a former Non-Exempt Employee who elected otherwise as provided in Schedule II) who is newly hired or rehired on or after October 1, 2005 but before January 1, 2010;

(B) any Exempt Employee who elected to participate in the AB II Benefit effective January 1, 2006 as described in Schedule II, in accordance with Section 4.01(b);

(C) any formerly Disabled Exempt Employee who elected to participate in the AB II Benefit upon return to active employment in accordance with Schedule II (5) or who became an AB II Participant automatically in accordance with Section 3.04;

(D) all Disabled Exempt Employees participating in the Plan on and after January 1, 2012.

(iv) certain other persons who elected to participate in the AB II Benefit or were transitioned to the AB II Benefit pursuant to the provisions of Plan 2006 Restatement, Schedule II or the transfer provisions of Section 3.04; and

This Article did not apply to any Non-Exempt Employee prior to January 1. 2008 (other than a formerly Exempt Employee who was an AB II Participant, transferred to a Non-Exempt Employee position, and remained an AB II Participant in accordance with the Plan's transfer provisions). In addition, this Article shall not apply to any Next Gen Employee.

(b) Election of AB II Benefit. Certain Participants shall be entitled (or were entitled) to elect to have their benefit accruals determined under this Article IV in accordance with the cash balance election provisions set forth in Schedule II of the Plan and as further described in the Plan 2006 Restatement.

4.02 AB II Benefit. Except as otherwise provided under this Article and subject to Article XIII, the AB II Benefit is the Participant's AB II Account, calculated in accordance with Section 4.03. Notwithstanding the foregoing, for benefit distributions occurring prior to January 1, 2008, the AB II Benefit was a monthly benefit equal to the Participant's AB II Account, increased with interest at the annual rate for Interest Credits in effect as of the

determination date to the Participant's Normal Retirement Date (if the Participant has not reached his Normal Retirement Date) and then converted to an Actuarial Equivalent Single Life Annuity commencing as of the Participant's Normal Retirement Date (or Late Retirement Date, if applicable).

For any AB II Participant, the AB II Benefit shall be used to determine the Participant's retirement benefit in accordance with the provisions of Articles VII and VIII and shall be subject to the Protected Benefit provisions of Section 4.07.

4.03 AB II Account.

(a) In General. On the date an Eligible Employee becomes an AB II Participant, an AB II Account shall be established for such AB II Participant. A Participant's AB II Account is a notional account equal to the sum of his—

(i) Opening Balance (if any), calculated pursuant to subsection (b) below;

(ii) Pay-Based Credits, calculated pursuant to Section 4.04; and

(iii) Interest Credits, calculated pursuant to Section 4.05.

An AB II Account shall be a bookkeeping account used to calculate the benefit of an AB II Participant under the Plan. The amounts credited to the AB II Account from time to time shall not represent any interest in any segregated assets of the Trust or otherwise create a right in any Participant, Beneficiary or other person to receive specific assets in the Trust. Benefits under the Plan shall be paid from the general assets of the Trust in the amounts and at the times provided under the terms of the Plan.

(b) Opening Balance. An Opening Balance shall be calculated for a Participant who becomes an AB II Participant in accordance with the provisions set forth below.

(i) FAP Benefit Conversions. In the case of a FAP Participant who becomes an AB II Participant, an Opening Balance shall be determined as follows:

(A) determine the Participant's Accrued Benefit under the Plan as of the Conversion Date;

(B) in the case of a Participant whose projected Credited Service to the first day of the month following the date the Participant would attain age 60, or actual Credited Service if over age 60, as of the date his Opening Balance is calculated does not equal or exceed 25 years, reduce the amount in clause (A) by 0.5% for each month between the first day of the month following the date the Participant attains age 65 and the later of (1) the Conversion Date or (2) the first day of the month following the date on which the Participant would attain age 60;

(C) in the case of a Participant whose projected Credited Service to the first day of the month following the date the Participant would attain age 60, or actual Credited Service if over age 60, as of the date his Opening Balance is calculated equals or exceeds 25 years, then apply no reduction; and

(D) calculate the lump sum Actuarial Equivalent of the amount in paragraph (B) or (C), as applicable, using the Actuarial Equivalent factors set forth in Section 1.08 for lump sum present value calculations, or with respect to Opening Balance calculations for all

Disabled Exempt Employees converting to the AB II Benefit on January 1, 2012, using an interest rate of 3.77%.

The result is equal to the Participant's Opening Balance. Notwithstanding the foregoing, if an Opening Balance is calculated pursuant to an election of the AB II Benefit as provided in subsection (4) or (5)(b) of Schedule II, the Participant's FAP Benefit shall not be reduced pursuant to paragraph (B) above if the Participant attains age 60 on or before the applicable Conversion Date.

(ii) AB I Benefit Conversions. In the case of any AB I Participant who becomes an AB II Participant, the Opening Balance shall be the balance of his AB I Account as of the Conversion Date, including any Pay-Based Credits and Interest Credits earned pro-rata for that Plan Year up until the Conversion Date.

(iii) Conversion After Reemployment. Effective January 1, 2008, in the case of a Participant who is receiving an annuity benefit as an AB II Participant, AB I Participant, or FAP Participant and who is reemployed, such benefits shall be suspended pursuant to Article XI. Subject to the exception for Next Gen Employees as described in Section 11.02, an Opening Balance shall be determined as of the applicable Conversion Date, equal to the lump sum present value of all remaining payments due the Participant based on the prior benefit election made under Article X of the Plan as if such reemployment had not occurred. The lump sum present value of such remaining payments shall be determined using the Actuarial Equivalent factors set forth in Section 1.08.

4.04 Pay-Based Credits. Effective as of the date a Participant becomes an AB II Participant and up until the time that the Participant has a Termination of Service or otherwise stops accruing a benefit under the AB II Benefit provisions, a Pay-Based Credit shall accrue to his or her AB II Account as of the last day of each Plan Year. The amount of the Pay-Based Credit shall equal a percentage of the Participant's Compensation for the Plan Year, plus an additional percentage of the Participant's Compensation in excess of one-half of the Taxable Wage Base for the Plan Year. The determination of Pay-Based Credits shall be based on the sum of the Participant's age and Point Service in accordance with the following table:

Age Plus Point Service	Percentage of Compensation	Percentage of Compensation Above ½ Taxable Wage Base
Fewer than 50	4.0%	1.0%
50-69	5.0%	1.0%
70 and over	6.0%	1.0%

For purposes of this Section, a Participant's age plus Point Service is calculated as follows:

(i) A Participant's age means the time period from the first day of the month following the date of the Participant's birth to the January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated.

(ii) A Participant's Point Service as of January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated is added to the Participant's age, calculated as described in (i) above.

(iii) The sum calculated in (ii) above, as rounded down into a whole integer, applies for purposes of this Section 4.04 for such Plan Year.

(iv) For the Plan Year that an AB II Participant has a Termination of Service, such AB II Participant shall receive a Pay-Based Credit based on Compensation and Point Service earned through the date of the Termination of Service.

4.05 Interest Credits. Interest Credits shall be credited to a Participant's AB II Account for each Plan Year as of December 31, based on the balance of the AB II Account as of the last day of the prior Plan Year (after Pay-Based Credits and Interest Credits are credited for that prior Plan Year). The rate used for determining Interest Credits (the "Interest Credit Rate") shall be equal to the annual interest rate on 30-year Treasury Securities, as determined and published by the Internal Revenue Service pursuant to Notice 2002-26, 2002-15 I.R.B. 743, for the month of September immediately preceding the first day of the Plan Year, but not less than 4%. The additional following provisions apply:

(a) For Year Payment Commences. In the case of a Participant who receives or begins to receive a distribution of his AB II Benefit prior to December 31 of a Plan Year, Interest Credits for such Plan Year shall be credited on a prorated basis to his AB II Account for the period from the prior December 31 until the date when the distribution is paid or commences. The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an Employee and the denominator of which is 12.

(b) For Initial Year of Participation. In the case of a Participant who becomes an AB II Participant during a Plan Year, Interest Credits shall be credited on a prorated basis based on the Opening Balance determined pursuant to Section 4.03(b). The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an AB II Participant and the denominator of which is 12.

(c) Interest Crediting After Termination. In the case of a Participant who has a Termination of Service and who is not vested in his AB II Account, Interest Credits shall not be credited to such Participant's AB II Account after such Termination of Service and shall not be credited for the period of absence from employment in the event the Participant is subsequently reemployed. If the Participant is subsequently reemployed, the Plan shall begin to credit Interest Credits to the Participant's Account (whether vested or nonvested) effective as of the date of the Participant's reemployment (however, for any Next Gen Employee, no additional Pay-Based Credits shall accrue). In the case of a Participant who has a Termination of Service and who is vested in his AB II Account, Interest Credits shall continue to be credited to such Participant's AB II Account as provided above in this Section up until the date the Participant begins distribution of his benefit.

(d) Market Rate of Return Rules. The Interest Credit Rate described above is intended not to exceed a "market rate of return" as set forth in Code Section 411(b)(5)(B) and as further described in Proposed Treasury Regulation Section 1.411(b)(5)-1(d) and may be modified in a future amendment if required by finalized Treasury Regulations or other guidance. In addition, upon the termination of the Plan, the following shall apply: (1) the rate of interest used to determine accrued benefits under the Plan shall be equal to the average of rates of interest used under the Plan during the 5-year period ending on the termination date; and (2) the interest rate and mortality table used to determine the amount of any benefit under the Plan payable in the form of an annuity payable at Normal Retirement Age shall be the rate and table specified under the Plan for such purpose as of the termination date, except that if such interest rate is a variable rate, the interest rate shall be determined under the rules of subclause (1).

4.06 No Supplement for Age 60 Retirement. No Participant participating in the AB II Benefit shall be eligible for the supplemental payment described in Section 5.06 and 6.03.

4.07 Protected Benefit for AB II Participant. In no event shall the Accrued Benefit due any Participant under the AB II Benefit provisions of the Plan be less than the amount protected under (a) or (b) below.

(a) Transition from FAP Benefit to AB II Benefit. If a Participant transitions from participation under the FAP Benefit to the AB II Benefit, such Participant's Accrued Benefit shall be no less than the sum of (i) his FAP Benefit determined under Article VI as of the applicable Conversion Date, and (ii) his AB II Benefit as of his Termination of Service (calculated without regard to his Opening Balance).

(b) Transition from AB I Benefit to AB II Benefit. For a Participant who transitions from the FAP Benefit to the AB I Benefit before transitioning from the AB I Benefit to the AB II Benefit, such Participant's Accrued Benefit shall be no less than his FAP Benefit when it was converted to the AB I Benefit (expressed as a Single Life Annuity payable at the Participant's Normal Retirement Date, which does not include any supplemental benefit). Further, for a Participant who transitions from the AB I Benefit to the AB II Benefit, such Participant's Accrued Benefit shall be no less than the sum of (i) his AB I Benefit determined under Article V as of the Conversion Date from the AB I to the AB II Benefit, and (ii) his AB II Benefit as of his Termination of Service (calculated without regard to his Opening Balance under the AB II Benefit provisions).

In addition to the preservation of the above-stated Protected Benefit, the Plan shall also preserve any other benefit, right or feature that is required by law to be preserved with respect to any Participant, including the use of any applicable actuarial equivalence or conversion factors or the availability of any additional forms of distribution.

4.08 Transition of Participants to the AB II Benefit. Notwithstanding anything to the contrary, any Participant described under this subsection 4.08 (who is not already an AB II Participant) shall accrue a benefit pursuant to the AB II Benefit provisions of this Article IV. Specifically, effective as of the dates indicated, the AB II Benefit provisions shall apply to: (1) any active Exempt Employee who is accruing a benefit under the Plan on or after January 1, 2011; (2) any Disabled Exempt Employee who is accruing a benefit under the Plan on or after January 1, 2012; and (3) any Non-Exempt Employee who is accruing a benefit under the Plan on or after January 1, 2013 (including any Disabled Non-Exempt Employee).

In connection with the January 1, 2011 and January 1, 2013 conversions of benefits of Employees to the AB II Benefit, all previously accrued frozen FAP Benefits will be converted to an AB II Benefit for all active Exempt Employees and active Non-Exempt Employees (as well as Disabled Exempt or Non-Exempt Employees) who are accruing a benefit under this Plan (whether through continued employment, transfer, or rehire). Accordingly, with respect to any undistributed FAP Benefit earned during a prior period of employment (whether under this Plan or under another defined benefit plan of the Employer or a Related Employer), such frozen benefit will be converted to an Opening Balance in accordance with the provisions of the plan in which the frozen benefit was accrued. The conversion of a previously accrued frozen FAP Benefit will be effective on the following dates: (1) on January 1, 2011 for Participants (January 1, 2012, for applicable Disabled Participants) who are accruing an AB II Benefit as an active Exempt Employee on such date (or, if later, as of the date the Participant becomes an active Exempt Employee accruing an AB II Benefit under the Plan) or (2) on January 1, 2013 for Participants who are accruing an AB II Benefit as an active (or Disabled) Non-Exempt Employee on such date (or, if later, as of the date the Participant becomes an active Non-Exempt Employee accruing an AB II Benefit under the Plan). The Opening Balance (reflecting the converted frozen FAP Benefit) shall have the following conditions apply:

(i) The Opening Balance shall earn Interest Credits in accordance with the AB II Benefit provisions of the plan in which the frozen benefit was accrued (or if AB II Benefit provisions do not exist in such plan, then in accordance with the plan's AB I Benefit provisions).

(ii) If a Participant's converted frozen benefit was previously earned under a plan other than this Plan, such benefit shall remain in such plan and will be tracked separately from any benefit earned under this Plan.

(iii) If a Participant's converted frozen benefit was previously earned under this Plan, then for administrative simplicity, the Plan Administrator may, in its discretion, elect to track a Participant's previously accrued frozen benefit separately from the Participant's ongoing benefit under the Plan.

(iv) A Participant who has a benefit converted to an Opening Balance pursuant to this paragraph shall never receive less than the previously accrued frozen FAP Benefit earned prior to the conversion.

ARTICLE V

AB I BENEFIT

5.01 Applicability of Article. This Article V sets forth the benefit accrual provisions for any Participant who was an AB I Participant under the Plan at some point prior to the Effective Date. No additional benefit accruals under the Plan shall be governed by this Article V. This Article V also sets forth the provisions necessary to determine a Protected Benefit based on a prior AB I Benefit.

(a) Participants Entitled to AB I Benefit. The provisions of this Article shall apply in determining the Accrued Benefit for any Participant who is not an AB II Participant under Article IV and who was described as follows:

(i) any Participant who first became a Non-Exempt Employee on or after January 1, 2002 but before January 1, 2008;

(ii) any former Employee who became a Non-Exempt Employee on or after January 1, 2002 but before January 1, 2008 following a Termination of Service;

(iii) any Participant who elected to participate in the AB I Benefit pursuant to one of the election periods described in Schedule II of the Plan, in accordance with Section 5.01(b) below;

(iv) any Participant who became an Exempt Employee (newly hired or rehired) on or after January 1, 2002 but before October 1, 2005;

(v) any Participant (other than an Employee described in subsection (vi) below) who became an Exempt Employee (hired or rehired) on or after October 1, 2005 but before January 1, 2006; provided such Participant accrued benefits under the AB I Benefit provisions only until January 1, 2006 at which time such Participant participated under the AB II Benefit provisions;

(vi) any former Non-Exempt Employee who transferred employment to become an Exempt Employee on or after October 1, 2005 but before January 1, 2006; and

(vii) any Profit Sharing Participant (as defined in the NiSource Inc. Retirement Savings Plan) on December 31, 2001 (who is not now an AB II Participant), other than an employee of Energy USA Propane on such date.

Notwithstanding the foregoing, this Article V shall not apply to any Participant to which the AB II Benefit provisions of Article IV apply or to any Participant to which the FAP Benefit provisions of Article VI apply. In addition, this Article shall not apply to any Next Gen Employee.

(b) Election of AB I Benefit. Certain Participants were entitled to elect to have their benefit accruals determined under this Article V in accordance with the cash balance election provisions set forth in Schedule II of the Plan and as further described in the Plan 2006 Restatement.

5.02 AB I Benefit. Except as otherwise provided under this Article, the AB I Benefit is the Participant's AB I Account, calculated in accordance with Section 5.03. Notwithstanding the foregoing, for benefit distributions occurring prior to January 1, 2008, the AB I Benefit was a monthly benefit equal to the Participant's AB I Account, increased with interest at the annual rate for Interest Credits in effect as of the determination date to

the Participant's Normal Retirement Date (if the Participant has not reached his Normal Retirement Date) and then converted to an Actuarial Equivalent Single Life Annuity commencing as of the Participant's Normal Retirement Date (or Late Retirement Date, if applicable).

For any AB I Participant, the AB I Benefit shall be used to determine the Participant's retirement benefit in accordance with the provisions of Articles VII and VIII and shall be subject to the Protected Benefit provisions of Section 5.07.

5.03 AB I Account.

(a) In General. On the date an Eligible Employee becomes an AB I Participant, an AB I Account shall be established for such AB I Participant. A Participant's AB I Account is a notional account equal to the sum of his—

(i) Opening Balance (if any), calculated pursuant to subsection (b) below;

(ii) Pay-Based Credits, calculated pursuant to Section 5.04; and

(iii) Interest Credits, calculated pursuant to Section 5.05.

An AB I Account shall be a bookkeeping account used to calculate the benefit of an AB I Participant under the Plan. The amounts credited to the AB I Account from time to time shall not represent any interest in any segregated assets of the Trust or otherwise create a right in any Participant, Beneficiary or other person to receive specific assets in the Trust. Benefits under the Plan shall be paid from the general assets of the Trust in the amounts and at the times provided under the terms of the Plan.

(b) Opening Balance. An Opening Balance shall be calculated for a Participant who becomes an AB I Participant in accordance with the provisions set forth below.

(i) In the case of a FAP Participant who becomes an AB I Participant, an Opening Balance shall be determined as follows:

(A) determine the Participant's Accrued Benefit under the Plan (or the Union Plan in the case of a conversion from the Union Plan) as of the Conversion Date;

(B) in the case of a Participant whose projected Credited Service to the first day of the month following the date the Participant would attain age 60, or actual Credited Service if over age 60, as of the date his Opening Balance is calculated does not equal or exceed 25 years, reduce the amount in clause (A) by 0.5% for each month between the first day of the month following the date the Participant attains age 65 and the later of (a) the Conversion Date or (b) the first day of the month following the date on which the Participant would attain age 60; and

(C) in the case of a Participant whose projected Credited Service to the first day of the month following the date the Participant would attain age 60, or actual Credited Service if over age 60, as of the date his Opening Balance is calculated equals or exceeds 25 years, then apply no reduction; and

(D) calculate the lump sum Actuarial Equivalent of the amount in paragraph (B) or (C) using the Actuarial Equivalent factors set forth in Section 1.08 for lump sum present value calculations, or with respect to Opening Balance calculations occurring prior to

December 31, 2002, using an interest rate of 6% and the 83 GAM mortality table, based on a fixed blend of 50% male and 50% female.

(ii) The result is equal to the Participant's Opening Balance. Notwithstanding the foregoing, if an Opening Balance is calculated pursuant to the 2002 cash balance election periods described in Sections (1), (2) or (3) of Schedule II, the Participant's FAP Benefit shall not be reduced pursuant to clause (B) above if the Participant attains age 65 on or before the Conversion Date.

5.04 Pay-Based Credits. Effective as of the date a Participant becomes an AB I Participant and up until the time that the Participant has a Termination of Service or otherwise stops accruing a benefit under the AB I Benefit provisions (such as due to a transition to the AB II Benefit), a Pay-Based Credit shall accrue to his or her AB I Account as of the last day of each Plan Year. The amount of the Pay-Based Credit shall equal a percentage of the Participant's Compensation for the Plan Year, plus an additional percentage of the Participant's Compensation in excess of one-half of the Taxable Wage Base for the Plan Year. The determination of Pay-Based Credits shall be based on the sum of the Participant's age and Point Service in accordance with the following table:

Age Plus Point Service	Percentage of Compensation	Percentage of Compensation Above ½ Taxable Wage Base
Fewer than 45	5.0%	2.0%
45-59	6.5%	2.0%
60-74	8.0%	2.0%
75 and over	10.0%	2.0%

For purposes of this subsection, a Participant's age plus Point Service is calculated as follows:

(i) A Participant's age means the time period from the first day of the month following the date of the Participant's birth to the January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated.

(ii) A Participant's Point Service as of January 1 following the last day of the Plan Year for which the Pay-Based Credits are being calculated is added to the Participant's age, calculated as described in (i) above.

(iii) The sum calculated in (ii) above, as rounded down into a whole integer, applies for purposes of this Section 5.04 for such Plan Year.

(iv) For the Plan Year that an AB I Participant has a Termination of Service, such AB I Participant shall receive a Pay-Based Credit based on Compensation and Point Service earned through the date of the Termination of Service.

5.05 Interest Credits. Interest Credits shall be credited to a Participant's AB I Account for each Plan Year as of each December 31, based on the balance of the AB I Account as of the last day of the prior Plan Year (after Pay-Based Credits and Interest Credits are credited for that prior Plan Year). The rate used for determining Interest Credits (the "Interest Credit Rate") shall be equal to the annual rate of interest on 30-year Treasury Securities, as determined and published by the Internal Revenue Service pursuant to Notice 2002-26, 2002-15 I.R.B. 743, for the month of September immediately preceding the first day of the Plan Year, but not less than 4 percent. The additional following provisions apply:

(a) For Year Payment Commences. In the case of a Participant who receives or begins to receive a distribution of his AB I Benefit prior to December 31 of a Plan Year, Interest Credits for such Plan Year shall be credited on a prorated basis to his AB I Account for the period from the prior December 31 until the date when the distribution is paid or commences. The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an Employee and the denominator of which is 12.

(b) For Initial Year of Participation. In the case of a Participant who becomes an AB I Participant during a Plan Year, Interest Credits shall be credited on a prorated basis based on the Opening Balance determined pursuant to Section 5.03(b). The Interest Credits shall be determined by multiplying the Interest Credit Rate by a fraction, the numerator of which is the number of months in such Plan Year during which the Participant is an AB I Participant and the denominator of which is 12.

(c) Interest Crediting After Termination. In the case of a Participant who has a Termination of Service and who is not vested in his AB I Account, Interest Credits shall not be credited to such Participant's AB I Account after such Termination of Service and shall not be credited for the period of absence from employment in the event the Participant is subsequently reemployed. If the Participant is subsequently reemployed, the Plan shall begin to credit Interest Credits to the Participant's Account (whether vested or nonvested) effective as of the date of the Participant's reemployment (however, for any Next Gen Employee, no additional Pay-Based Credits shall accrue). In the case of a Participant who has a Termination of Service and who is vested in his AB I Account, Interest Credits shall continue to be credited to such Participant's AB I Account as provided above in this Section up until the date the Participant begins distribution of his benefit.

(d) Market Rate of Return Rules. The Interest Credit Rate described above is intended not to exceed a "market rate of return" as set forth in Code Section 411(b)(5)(B) and as further described in Proposed Treasury Regulation Section 1.411(b)(5)-1(d) and may be modified in a future amendment if required by finalized Treasury Regulations or other guidance. In addition, upon the termination of the Plan, the following shall apply: (1) the rate of interest used to determine accrued benefits under the Plan shall be equal to the average of rates of interest used under the Plan during the 5-year period ending on the termination date; and (2) the interest rate and mortality table used to determine the amount of any benefit under the Plan payable in the form of an annuity payable at Normal Retirement Age shall be the rate and table specified under the Plan for such purpose as of the termination date, except that if such interest rate is a variable rate, the interest rate shall be determined under the rules of subclause (1).

5.06 Supplement for Age 60 Retirement.

(a) Eligibility for Benefit. No Participant first participating in the Plan on or after January 1, 2002 shall be eligible for the supplemental payment described in this Section or in Section 6.03. Subject to the exclusion set forth in the foregoing sentence, an AB I Participant shall be entitled to receive a supplemental benefit if he has a Termination of Service (while participating in the Plan as an AB I Participant) after fulfilling all the requirements for a Normal Retirement Benefit or Early Retirement Benefit on or after age 60 and after completion of 25 years of Credited Service.

Notwithstanding the foregoing, pursuant to the transfer provisions in Section 3.04(b)(ii), any Employee with a frozen AB I Benefit under the Plan shall not be entitled to a supplemental benefit with regards to that frozen benefit unless such Employee has met the eligibility requirements set forth in this subsection on or before transferring to a Related Employer or to a position within the Employer that is subject to a different pension plan.

(b) Amount of Supplemental Benefit. If a Participant meets the eligibility conditions set forth in subsection (a) above, the Participant shall receive a supplemental payment equal to the Actuarial Equivalent of a monthly amount, commencing on the date of his retirement and continuing until the first day of the month in which the Participant reaches age 65, equal to 80% of his Maximum Primary Social Security Benefit, rounded to the next higher multiple of $10, in effect as of January 1, 2004.

(c) Payment. Notwithstanding the foregoing, if a Participant elects to receive his AB I Benefit in a lump sum pursuant to Section 10.03, the Actuarial Equivalent of the supplemental benefit determined under this Section shall be paid to the Participant in a single lump sum. If the Participant elects to receive his AB I Benefit in any annuity form provided in Article X, the supplemental benefit determined under this Section shall be paid in the form of a Single Life Annuity.

5.07 Protected Benefit for an AB I Participant. If a Participant transfers from the FAP Benefit provisions to the AB I Benefit provisions (such as pursuant to one of the election periods set forth in Schedule II), then such Participant's Accrued Benefit shall be no less than the Accrued Benefit that would have been payable (expressed as a Single Life Annuity payable at the Participant's Normal Retirement Date) under the provisions of the Plan in effect on the Conversion Date established for the applicable Participant election. This Protected Benefit provision shall continue to apply with respect to any AB I Participant that subsequently transfers to become an AB II Participant.

ARTICLE VI

FAP BENEFIT

6.01 Applicability of Article. This Article VI sets forth the benefit accrual for any Participant who was a FAP Participant under the Plan at some point prior to the Effective Date. No additional benefit accruals under the Plan shall be governed by this Article VI. This Article VI also sets forth the provisions necessary to determine a Protected Benefit based on a prior FAP Benefit.

Unless a Participant is an AB II Participant under Article IV or an AB I Participant under Article V, the provisions of this Article VI shall apply in determining the Accrued Benefit for any Employee who first became an Eligible Employee prior to January 1, 2002.

In accordance with Section 6.02(b), the provisions of this Article VI shall only apply in determining a Participant's Accrued Benefit with respect to the period up to and including his Conversion Date.

This Article VI shall not apply to (1) any Exempt Employee accruing a benefit under the Plan on or after January 1, 2011; (2) any Disabled Exempt Employee accruing a benefit under the Plan on or after January 1, 2012; or (3) any Non-Exempt Employee (including any Disabled Non-Exempt Employee) accruing a benefit under the Plan on or after January 1, 2013.

6.02 FAP Benefit.

(a) General Rule. Except as otherwise provided in this Section and subject to the limitations of Article XIII, a Participant's FAP Benefit is a monthly benefit, calculated as a Single Life Annuity commencing on the Participant's Normal Retirement Date, that is equal to the greater of the amounts determined under (i) or (ii) below.

(i) The sum of the following:

(A) 1.70 percent of the Participant's Final Average Pay multiplied by the Participant's years of Credited Service up to a maximum of 30 years; and

(B) 0.60 percent of the Participant's Final Average Pay multiplied by the Participant's years of Credited Service in excess of 30 years.

(ii) With respect to the calculation of the Normal Retirement Benefit (as defined under Section 7.01), such benefit shall be no less than $350.00 if the Participant terminates employment on or after June 1, 1990; or $250.00 if the Participant terminates employment prior to June 1, 1990.

(b) FAP Benefit Provisions Applicable to Former NIFL Employees and Former Kokomo Employees. For any Participants who are Former NIFL Employees or Former Kokomo Employees, the provisions of subsection (a) above shall not apply and the following provisions shall apply instead:

(i) Subject to the limitations of Article XIII, a Former NIFL Employee's FAP Benefit is a monthly benefit calculated as a Single Life Annuity commencing at the Participant's Normal Retirement Date that is equal to the greater of the amounts determined under (A) or (B) below:

(A) The sum of paragraphs 1. and 2. below:

1. Pre-1994 Benefit. The benefit accrued by the Participant on December 31, 1993 under the Northern Indiana Fuel and Light Company, Inc. Retirement Plan (the "NIFL Prior Plan") in which he participated on that date, multiplied by a fraction (not less than 1.0), the numerator of which is his Final Average Pay on his date of his Termination of Service with the Employer and all Related Employers, and the denominator of which is his Final Average Pay on December 31, 1993. For purposes of this subsection (1), the benefit accrued by the Participant under the NIFL Prior Plan as of December 31, 1993 shall be determined pursuant to all of the terms and conditions of the NIFL Prior Plan on December 31, 1993 (including calculation of any benefit earned under the NIFL Prior Plan to be a benefit with its "normal" form as a single-life 10-year term certain annuity) except that Final Average Pay shall be as defined in Section 1.30. Another way of stating the calculation of this Pre-1994 Benefit for purposes of this subsection (A)(1) is as follows: 1.08% of a Participant's Final Average Pay on his date of Termination of Service multiplied by his years of Credited Service accrued through December 31, 1993.

2. Post-1993 Benefit. 1.7% of Final Average Pay for each year of Credited Service completed by the Participant after December 31, 1993, up to a maximum of 30 years, plus 0.6% of Final Average Pay for each year of Credited Service completed by the Participant after December 31, 1993 in excess of 30 years.

In no event shall the FAP Benefit of the Participant be less than the benefit accrued by the Participant under the terms of the NIFL Prior Plan on December 31, 1993, computed pursuant to the terms and conditions of such NIFL Prior Plan on such date. In addition, in no event shall the FAP Benefit exceed 1.7% of Final Average Pay for each year of Credited Service completed by the Participant up to a maximum of 30 years, plus 0.6% of Final Average Pay for each year of Credited Service completed by the Participant in excess of 30 years.

(B) The FAP Benefit on a termination basis (within the meaning of Treasury Regulation Section 1.414(l)), to which any Former NIFL Employee is entitled under the Plan shall, immediately after January 1, 1995, be equal to or greater than the benefit to which such Participant was entitled on a termination basis, under the NIFL Prior Plan.

(ii) Subject to the limitations of Article XIII, a Former Kokomo Employee's FAP Benefit is a monthly benefit calculated as a Single Life Annuity commencing at the Participant's Normal Retirement Date that is equal to the greatest of the amounts determined under (A), (B) and (C) below:

(A) The sum of paragraphs 1. and 2. below:

1. Pre-1994 Benefit. The benefit accrued by the Participant on December 31, 1993 under the Kokomo Gas and Fuel Company Non-Bargaining Unit Employees' Pension Plan (the "Kokomo Prior Plan") in which he participated on that date, multiplied by a fraction (not less than 1.0), the numerator of which is his Final Average Pay on his date of his Termination of Service with the Employer and all Related Employers, and the denominator of which is his Final Average Pay on December 31, 1993. For purposes of this subsection (1), the benefit accrued by the Participant under the Kokomo Prior Plan as of

December 31, 1993 shall be determined pursuant to all of the terms and conditions of the Kokomo Prior Plan on December 31, 1993 except that Final Average Pay shall be as defined in Section 1.30.

2. Post-1993 Benefit. 1.7% of Final Average Pay for each year of Credited Service completed by the Participant after December 31, 1993, up to a maximum of 30 years, plus 0.6% of Final Average Pay for each year of Credited Service completed by the Participant after December 31, 1993 in excess of 30 years.

In no event shall the FAP Benefit of the Participant be less than the benefit accrued by the Participant under the terms of the Kokomo Prior Plan on December 31, 1993, computed pursuant to the terms and conditions of such Kokomo Prior Plan on such date. In addition, in no event shall the FAP Benefit exceed 1.7% of Final Average Pay for each year of Credited Service completed by the Participant up to a maximum of 30 years, plus 0.6% of Final Average Pay for each year of Credited Service completed by the Participant in excess of 30 years.

(B) The FAP Benefit on a termination basis (within the meaning of Treasury Regulation Section 1.414(l)), to which any Former Kokomo Employee is entitled under the Plan shall, immediately after January 1, 1995, be equal to or greater than the benefit to which such Participant was entitled on a termination basis, under the Kokomo Prior Plan.

(C) Notwithstanding any provision to the contrary contained in the Plan, the FAP Benefit of a Participant who is a Former Kokomo Employee shall not be less than 1.4% of Final Average Pay for each year of Credited Service completed by the Participant.

(c) Date of Determination. Notwithstanding subsection (a) or (b), in the case of a Participant who transitions to the AB II Benefit or the AB I Benefit (either automatically or by election), the Participant's FAP Benefit (for purposes of determining the Protected Benefit or, if applicable, a frozen FAP Benefit) shall be determined without regard to any Compensation paid or Credited Service earned after his Conversion Date (other than Compensation or Credited Service attributable to any subsequent period when the Participant again becomes a FAP Participant, if applicable).

6.03 Supplement for Age 60 Retirement.

(a) Eligibility for Benefit. A Participant shall be entitled to receive a supplemental retirement benefit if he or she:

(i) is described in Section 6.01;

(ii) has a Termination of Service at or after reaching age 60 and after completing 25 years of Credited Service; and

(iii) is a FAP Participant at the time of his Termination of Service.

(iv) Notwithstanding the foregoing, pursuant to the transfer provisions in Section 3.04(b)(ii), any Employee with a frozen FAP Benefit under the Plan shall not be entitled to a supplemental benefit with regards to that frozen benefit unless such Employee has met the eligibility

requirements set forth in this subsection on or before transferring to a Related Employer or to a position within the Employer that is subject to a different pension plan.

(b) Amount of Supplemental Benefit. A Participant who becomes entitled to a supplemental benefit under this Section shall be entitled to a monthly benefit increase until the first day of the month in which the Participant reaches age 65 or, if earlier, the date on which he becomes entitled to receive a Disability Insurance Benefit under the Social Security Act, as amended, by an amount equal to 80% of his Maximum Primary Social Security Benefit, rounded to the next higher multiple of $10, in effect as of January 1, 2004. This supplemental benefit amount is a set monthly amount of $1,430 for all FAP Participants who are eligible to receive such supplement.

(c) Payment. Regardless of the form of annuity payment of the Participant's FAP Benefit paid under Article X, the supplemental benefit determined under this Section shall be paid in a Single Life Annuity.

6.04 Grandfathered Pension Increases. Certain pension increases shall be provided to FAP Participants who previously terminated employment in accordance with the provisions set forth below.

(a) Except as provided in the further provisions of this Section, effective as of March 1, 1990, there shall be a 4% increase in the annuity benefit payable to or on behalf of any Participant whose employment terminated prior to March 1, 1990 with entitlement to an annuity benefit under the Plan or any other prior plan.

(b) Except as provided in the further provisions of this Section, effective as of June 1, 1995, there shall be a 2% increase in the annuity benefit payable to or on behalf of any Participant whose employment terminates prior to June 1, 1995 with entitlement to a benefit under the Plan or any other prior plan.

(c) Except as provided in the further provisions of this Section, effective as of January 1, 1998, there shall be a 2% increase in the annuity benefit payable to or on behalf of any Participant whose employment terminated prior to January 1, 1998 with entitlement to an annuity benefit under the Plan or any other prior plan.

(d) Except as provided in the further provisions of this Section, effective as of June 1, 2003, there shall be a 2% increase in the annuity benefit payable to or on behalf of any Participant whose employment terminated or terminates prior to June 1, 2003 with entitlement to an annuity benefit under the Plan or any other prior plan.

(e) Any such increases shall be subject to, and determined in accordance with, the following:

(i) None of the increases in subsections (a), (b) or (c) shall be applicable with respect to any annuity benefit that commenced less than two (2) months prior to the effective date of said increase;

(ii) The increase in subsection (d) shall be inapplicable with respect to any annuity benefit that commenced less than three (3) months prior to the effective date of said increase;

(iii) None of the increases in subsections (a), (b), (c) or (d) shall be applicable with respect to any Participants eligible for a Deferred Vested Benefit, or their Spouses (with respect to spousal benefits under 9.02(b) or 10.01(b)), or any Early Retirement Benefit for Participants with less than 20 years of Service, or their Spouses, unless the Participant is, or would have been, age 65 or older on the effective date of the increase; and

(iv) None of the increases in subsections (a), (b), (c) or (d) shall be applicable with respect to any Early Retirement Benefit supplements or Disability Benefit supplements under the Plan or any other prior plan.

(v) Any such increase pursuant to this Section shall be computed on the basis of the amount of annuity benefit payable as of the month preceding the respective effective date, without regard to the form of payment or reduction factors applied with respect to early payment of benefits, or whether payable to a Participant or a Spouse

ARTICLE VII

RETIREMENT BENEFITS

7.01 Normal Retirement Benefit.

(a) Eligibility. Subject to the provisions of Article X, a Participant who attains Normal Retirement Age while employed by the Company or a Related Employer shall be eligible for a Normal Retirement Benefit under the Plan. This "Normal Retirement Benefit" shall be calculated as a Single Life Annuity commencing on the Participant's Normal Retirement Date. If a Participant remains employed after his Normal Retirement Date, benefit payments under this Section may be suspended under Article XI.

(b) Amount and Payment. Except as otherwise provided in this Section and subject to the limitations of Article XIII, a Participant who becomes entitled to receive a Normal Retirement Benefit under this Section shall be entitled to a monthly benefit equal to the Participant's Accrued Benefit. A Participant's Normal Retirement Benefit shall be paid after a Termination of Service in accordance with Article X.

(c) Minimum Accrued Benefit. Notwithstanding any provision to the contrary, in accordance with Code Section 411(a)(9), in no event shall the Normal Retirement Benefit be less than the largest periodic benefit that would have been payable to the Participant upon Termination of Service at or prior to Normal Retirement Age under the Plan, exclusive of social security supplements (if any) and the value of disability benefits (if any) not in excess of the Normal Retirement Benefit. For purposes of comparing periodic benefits in the same form, commencing prior to and at Normal Retirement Age, the greater benefit is determined by converting the benefit payable prior to Normal Retirement Age into the same form of annuity benefit payable at Normal Retirement Age and comparing the amount of such annuity payments. In the case of a top-heavy plan, the Normal Retirement Pension shall not be smaller than the minimum benefit to which the Participant is entitled under Article XVIII.

7.02 Late Retirement Benefit.

(a) Eligibility. Subject to the provisions of Article X, a Participant who remains an Employee beyond his Normal Retirement Date shall be eligible for a late retirement benefit under the Plan. This late retirement benefit shall be calculated as a Single Life Annuity commencing on the Participant's Late Retirement Date.

(b) Amount and Payment. Except as otherwise provided in this Section and subject to the limitations of Article XIII, a Participant who becomes eligible to receive a late retirement benefit under this Section shall be entitled to a monthly benefit equal to the Participant's Accrued Benefit. In no event shall a late retirement benefit under this Section be less than the greatest monthly Normal Retirement Benefit the Participant would have been entitled to receive if he had elected to retire at Normal Retirement Age. A Participant's late retirement benefit shall be paid after a Termination of Service in accordance with Article X and Article XI.

(c) Adjustment for Required Minimum Distributions. In the case of any Participant (such as a "five percent owner" as defined in Code Section 416) whose retirement benefits commence prior to his Termination of Service pursuant to Section 10.07, the Participant's benefit shall be adjusted, if appropriate, as of January 1 of each year beginning after the Participant's Benefit Commencement Date to reflect additional accruals under the Plan for the immediately preceding calendar year.

7.03 Early Retirement Benefit.

(a) Eligibility. Subject to the provisions of Article X, a Participant who has a Termination of Service on or after attaining his Early Retirement Age, but before such Participant reaches Normal Retirement Age, shall be eligible for an "Early Retirement Benefit" calculated as a Single Life Annuity commencing on his Early Retirement Date. If a Participant is reemployed after his Early Retirement Date, benefit payments under this Section may be suspended under Article XI.

(b) Amount and Payment. Subject to the limitations of Article XIII, the Early Retirement Benefit shall be determined and paid depending on whether the Participant is an AB II Participant, AB I Participant or FAP Participant as described below. A Participant's Early Retirement Benefit shall be paid commencing on his Early Retirement Date in accordance with Article X.

(i) For AB II or AB I Participants. The Early Retirement Benefit for any AB II Participant or any AB I Participant, as applicable, shall be a monthly benefit equal to the Actuarial Equivalent of the Participant's Accrued Benefit determined as of the Benefit Commencement Date, including consideration of a Protected Benefit calculation (if applicable) which applies the early retirement reduction factors set forth in subparagraph (ii) below.

(ii) For FAP Participants. The Early Retirement Benefit for any FAP Participant shall be a monthly benefit equal to the Participant's FAP Benefit with adjustment based on the Benefit Commencement Date and the amount of Credited Service completed at Termination of Service as set forth below. The calculation set forth in this subsection (ii) shall also apply for calculating the Protected Benefit (if applicable) of an AB II or AB I Participant retiring under this Section 7.03.

(A) Early Retirement After 25 Years of Credited Service. The Early Retirement Benefit payable before attainment of age 65 to any Participant who has completed 25 years or more of Credited Service shall be reduced as shown in the following table, provided that no Early Retirement Benefit shall be reduced below $350.00 per month.

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

(B) Early Retirement After 25 Years of Credited Service for Former NIFL Employees and Former Kokomo Employees. For any Participants who are Former NIFL Employees

or Former Kokomo Employees, the provisions of subsection (A) above shall not apply and this subsection (B) shall apply instead. The Early Retirement Benefit payable before attainment of age 65 to any Participant who is a Former NIFL Employee or a Former Kokomo Employee who has completed 25 years or more of Credited Service shall be reduced by 0.5% for each month or partial month that commencement of the Early Retirement Benefit precedes the date the Participant attains age 60.

(C) Early Retirement Prior to 25 Years of Credited Service. If payment of an Early Retirement Benefit commences prior to age 65 with respect to any Early Retirement Benefit payable after fewer than 25 years of Credited Service, the amount of such benefit shall be reduced by 6% for each of the first five years and 4% for each of the next five years that commencement of the Early Retirement Benefit precedes the Participant's Normal Retirement Date with a pro rata reduction for any fraction of a year.

Notwithstanding the foregoing, no Early Retirement Benefit shall be reduced below $250 if the Participant had less than 20 years of Credited Service at his Termination of Service, or $350 if the Participant had 20 or more years of Credited Service at his Termination of Service. The foregoing sentence shall apply for all Participants except those Participants that are Former NIFL Employees or Former Kokomo Employees who maintain a benefit under the Plan on and after December 31, 2012 pursuant to the merger of the Subsidiary Plan into the Plan effective as of such date.

(c) Voluntary Retirement Programs. Notwithstanding the preceding provisions, special Early Retirement Benefits and reduction factors shall be calculated pursuant to the applicable Appendix for an eligible Participant who elects to retire under a Early Retirement Program offered by the Employer and who otherwise satisfies the requirements of the applicable Appendix.

7.04 Disability Benefit.

(a) In General. If a Participant becomes Disabled while employed by the Employer prior to the attainment of his Normal Retirement Age, he will be deemed to receive Credited Service, Point Service and Compensation for the duration of the period during which he remains Disabled (but in no event after his attainment of his Normal Retirement Age) in accordance with the Compensation and service crediting provisions set forth in Articles I and II, respectively. Accordingly, with respect to an AB II Participant or an AB I Participant, the Plan Administrator shall continue to maintain an AB II or AB I Account, as applicable, on behalf of the Participant during such period of Disability, with Pay-Based Credits and Interest Credits continuing to be made to the Participant's AB II or AB I Account, as applicable, for the duration of the Disability. Moreover, with respect to a FAP Participant, except as otherwise provided in subsection (b) below, a Participant who becomes Disabled shall continue to receive Credited Service for purposes of calculating the FAP Benefit in accordance with Article II. Upon a Disabled Participant attaining his Normal Retirement Date or Early Retirement Date, such Participant shall be entitled to receive a benefit in accordance with Section 7.01 or Section 7.03, as applicable. Further, if the Participant is deemed to have a Termination of Service (prior to Normal or Early Retirement Age), such Participant shall be entitled to receive a benefit in accordance with the provisions of Article VIII.

(b) Special FAP Disability Benefit. Notwithstanding the provisions of subsection (a) above, a FAP Participant who meets the eligibility requirements of this subsection (b) shall be eligible for the benefit described in subsection (ii) below (the "FAP Disability Benefit").

(i) Eligibility. A FAP Participant shall be eligible for a FAP Disability Benefit if he/she becomes Disabled while employed by the Employer, if employment is terminated after completion of three or more years of Credited Service, and if such Participant is Disabled due to an injury on the job other than an intentionally self-inflicted injury. For FAP Participants who became Disabled prior to January 1, 2003, certain other service requirements applied as set forth in the Plan 2006 Restatement. Former NIFL Employees and Former Kokomo Employees are not eligible for the Special FAP Disability Benefit.

(ii) Timing and Amount. Payment of a FAP Disability Benefit shall commence as of the first day of the month next following the date of entitlement thereto. The FAP Disability Benefit shall be a monthly amount, determined on a single-life basis, equal to the greater of (1) your Accrued Benefit or (2) $350. The benefit shall not be reduced for payment commencing prior to age 65. In addition, the benefit shall be computed as if such FAP Participant had not less than 25 years of Credited Service.

A FAP Disability Benefit shall be based upon the Final Average Pay of the Participant determined immediately prior to the date he commenced receiving benefits under the long term disability plan of the Company or any other Employer, or if he is not eligible to receive such long term disability benefits, determined as of the date such Participant's employment with the Company and all other Employers and Related Employers terminates. If a FAP Participant who is entitled to receive a FAP Disability Benefit submits proof to the Plan Administrator that he has not been accepted by the Social Security Administration for Social Security disability benefits, his annuity benefit shall be increased until the first day of the month in which the Participant reaches age 65 or such other age at which Disability Insurance Benefits become payable under the Social Security Act, as amended, by an amount equal to 80% of his Maximum Primary Social Security Benefit, rounded to the next higher multiple of $10.

7.05 Nonduplication of Benefits. The amount of a Participant's retirement benefits shall be reduced by any retirement income payable from any source other than the Trust, to which a Participant is entitled under any tax qualified defined benefit plan of a Related Employer, attributable to a period of employment for which he receives a benefit from the Plan. For the purpose of computing the amount of such reduction, if the payment of other retirement income is to commence other than at the Employee's Normal Retirement Date under this Plan, or is to be made on a basis other than a retirement income for life, such other payment shall be recomputed to its Actuarial Equivalent value on the basis of a retirement income for life commencing on such Normal Retirement Date.

ARTICLE VIII

TERMINATION OF SERVICE; PARTICIPANT VESTING

8.01 Termination of Service Prior to Normal or Early Retirement or Death. Upon Termination of Service prior to a Participant's Normal or Early Retirement Date (for any reason other than death), such Participant shall be entitled to a Vested retirement benefit (a "Deferred Vested Benefit") that has become nonforfeitable in accordance with the provisions of Section 8.02. This Deferred Vested Benefit shall be calculated as a Single Life Annuity and shall be determined and paid depending on whether the Participant is an AB II Participant, AB I Participant or FAP Participant as described below. If a Participant is reemployed after commencing benefits, benefit payments under this Section may be suspended under Article XI. In addition to the payment provisions set forth below, a Participant's Deferred Vested Benefit shall be paid in accordance with Article X and subject to the limitations of Article XIII.

(a) For AB II or AB I Participants.

(i) Timing. An AB II Participant or AB I Participant may elect to begin receiving the Deferred Vested Benefit as soon as administratively practicable (generally the first of the month) following the Participant's Termination of Service, or the first day of any month thereafter. Such date shall be considered the Participant's "Vested Retirement Date."

(ii) Amount. The Deferred Vested Benefit of a terminated AB II Participant or AB I Participant shall be calculated as follows:

(A) If the Participant commences the Deferred Vested Benefit on his or her Normal Retirement Date, the Participant shall be entitled to a monthly benefit equal to his Accrued Benefit.

(B) If the Participant commences the Deferred Vested Benefit on or after reaching Early Retirement Age but before Normal Retirement Age, the Participant shall be entitled to a monthly benefit equal to the Actuarial Equivalent of the Participant's Accrued Benefit determined as of the Benefit Commencement Date, including consideration of a Protected Benefit calculation (if applicable) which applies the early retirement reduction factors set forth in Section 8.01(b)(ii)(B).

(C) If the Participant commences the Deferred Vested Benefit prior to reaching an Early or Normal Retirement Age, the Participant shall be entitled to a monthly benefit equal to the Actuarial Equivalent of the Participant's Accrued Benefit determined as of the Benefit Commencement Date, including consideration of a Protected Benefit calculation which applies the Actuarial Equivalent factors set forth in Section 1.08.

(b) For FAP Participants.

(i) Timing. If a FAP Participant has a Termination of Service prior to attaining Normal or Early Retirement Age, such Participant may elect to begin receiving the Deferred Vested Benefit on the first day of any month following attainment his or her Early Retirement Age. Such date shall be considered the Participant's "Vested Retirement Date."

(ii) Amount. The Deferred Vested Benefit of a terminated FAP Participant shall be calculated as follows:

(A) If the Participant commences the Deferred Vested Benefit on his or her Normal Retirement Date, the Participant shall be entitled to a monthly benefit equal to the greater of (1) or (2) as follows:

1. his Accrued Benefit;

2. For all Participants except those Participants who are Former NIFL Employees or Former Kokomo Employees, $25.00 ($20.00 if the Participant's Termination of Service occurred prior to January 1, 1990) multiplied by his years of Credited Service up to a maximum of 10 years.

(B) If the Participant commences the Deferred Vested Benefit on or after reaching Early Retirement Age but before Normal Retirement Age, the Deferred Vested Benefit for any FAP Participant (or with respect to the calculation of any Protected Benefit, if applicable) shall equal the Participant's FAP Benefit reduced by 6% for each of the first 5 years and 4% for each of the next 5 years by which the Participant's Benefit Commencement Date precedes the Participant's Normal Retirement Date, with a pro rata reduction for any fractional portion of a year. Notwithstanding the foregoing, for all Participants except those Participants who are Former NIFL Employees or Former Kokomo Employees, such Deferred Vested Benefit shall not be reduced below an amount equal to $25 ($20, for Participants terminating prior to June 1, 1990) multiplied by the Participant's years of Credited Service up to a maximum of 10 years

8.02 Vesting.

A Participant's Accrued Benefit is 100% Vested upon and after his attaining Normal Retirement Age (if employed by a Related Employer on or after that date). If a Participant's employment terminates prior to Normal Retirement Age, then for each Year of Vesting Service, such Participant shall receive a Vested percentage of his Accrued Benefit equal to the following:

Years of Vesting Service	Percent of Vested Accrued Benefit
Less than 3	0%
At least 3 or more	100%

Notwithstanding the foregoing, for Participants terminating employment prior to January 1, 2008, the Plan applied a 5-year cliff vesting schedule, rather than the 3-year cliff vesting schedule set forth above.

8.03 Included Years of Vesting Service.

All of a Participant's years of Vesting Service shall be taken into account for purposes of the Plan, except as set forth herein. If a Participant with a 0% Vested Accrued Benefit incurs a Break in Service, the Plan Administrator shall disregard his years of Vesting Service before the Break in Service if the number of the Employee's consecutive one-year Breaks in Service equals or exceeds the greater of 5 or the aggregate number of the Employee's years of Vesting Service prior to such break. The aggregate number of years of Vesting Service before a Break in Service does not include any years of Vesting Service not required to be taken into account under this exception by reason of any prior Break in Service. If the Plan Administrator disregards the

Participant's years of Vesting Service under this exception, the Plan forfeits his pre-Break in Service Accrued Benefit.

8.04 Deemed Cash-Out Provision for Non-Vested Participants.

A "deemed" cash-out rule applies to a 0% Vested Participant. The Plan Administrator shall treat a 0% Vested Participant as having received a cash-out distribution on the date of the Participant's Termination of Service. Upon the reemployment of such a Participant prior to five (5) consecutive one-year Breaks in Service, the Participant's entire Accrued Benefit shall be restored. However, if such Participant is not re-employed with the Employer prior to five (5) consecutive one year Breaks in Service, the Plan Administrator shall disregard the Participant's prior Accrued Benefit when determining the Participant's Accrued Benefit earned after his re-employment.

ARTICLE IX

DEATH BENEFITS

9.01 Death On Or After Benefit Commencement Date. Upon the death of any Participant on or after his Benefit Commencement Date, whether or not the Participant had actually received the first payment of his benefit, the death benefit, if any, payable to the Participant's Beneficiary (including a joint annuitant) shall be determined in accordance with the payment form selected by the Participant.

9.02 Death Prior to Benefit Commencement Date. If a Participant dies before his Benefit Commencement Date but after attaining a vested right to his Accrued Benefit, a death benefit may be payable under this Article. This death benefit shall be separately determined and paid depending on whether the Participant is an AB II Participant, AB I Participant or FAP Participant as described below.

(a) Death Benefit for AB II or AB I Participants.

(i) Eligibility. Upon the death of either an AB II Participant or an AB I Participant (regardless of whether single or married) prior to his or her Benefit Commencement Date, a death benefit shall be paid in accordance with this Section 9.02(a) to such Participant's Spouse or other Beneficiary or Beneficiaries, subject to the spousal consent requirement set forth in this Article.

(ii) Amount and Form.

(A) Spousal Death Benefit. Unless a valid waiver election has been made pursuant to Section 9.04, the Plan Administrator shall direct the Trustee to distribute the death benefit of a married AB II Participant or AB I Participant, as applicable, to such Participant's surviving Spouse as a Preretirement Survivor Annuity. A "Preretirement Survivor Annuity" for purposes of an AB II Participant's or an AB I Participant's benefit is a Single Life Annuity payable for the life of the surviving Spouse equal to the greater of the following:

1. the Actuarial Equivalent of the Participant's AB II Account or AB I Account, as applicable, at the time payments commence; or

2. the survivor annuity portion of the QJSA set forth in Section 10.01 calculated in accordance with Code Section 417(c) and based on the Participant's Accrued Benefit (including consideration of the Participant's Protected Benefit).

In lieu of this monthly annuity, the Spouse Beneficiary can elect to receive the Participant's AB II Account or AB I Account, as applicable, payable as a single lump sum payment.

(B) Non-Spousal Death Benefit. If the Participant is not married or has made a valid waiver election pursuant to Section 9.04, the death benefit payable to a non-Spouse Beneficiary shall equal the Participant's AB II Account or AB I Account, as applicable, and shall be paid in the form of a single lump sum payment.

(iii) Timing of Payment. Any lump sum death benefit shall be paid as soon as practicable after the Participant's death. The Preretirement Survivor Annuity described in paragraph (ii) above shall commence as of the first day of the month following the Participant's death. Alternatively, a surviving Spouse may elect to defer commencement of such annuity until the first day of any calendar month coinciding with or next following the date on which the Participant would have attained age 65, but no later than that date. Notwithstanding the foregoing, any death benefit payments shall be subject to the minimum distribution requirements of Section 10.07.

(b) Death Benefit for FAP Participants.

(i) Eligibility. If a FAP Participant dies before his or her Benefit Commencement Date and is married at the time of his or her death, a death benefit shall be paid in accordance with this Section 9.02(b) to such Participant's Spouse. If a FAP Participant dies before his or her Benefit Commencement Date and is not married at the time of his or her death, no death benefit shall be paid under the Plan.

(ii) Amount and Form. The benefit payable pursuant to this subsection (b) shall be paid in the form of a monthly benefit payable to the surviving Spouse for his or her lifetime. This preretirement death benefit shall be paid in an amount equal to a survivor annuity as if the Participant had (1) terminated employment immediately preceding death (if not already terminated), (2) elected to receive a joint and 50% survivor annuity with respect to the FAP Benefit commencing on the earliest date on which, under the Plan, a Participant could elect to receive a retirement benefit, and (3) died on the day after such benefit commenced.

Accordingly, the following shall apply:

(A) If a Participant dies after reaching Normal Retirement Age under the Plan, then the surviving Spouse shall receive the survivor annuity portion of a 50% joint and survivor annuity that is based on the Participant's Normal Retirement Benefit.

(B) If a Participant dies after reaching Early Retirement Age under the Plan (age 55 with 10 years of Credited Service), then the surviving Spouse shall receive the survivor annuity portion of a 50% joint and survivor annuity that is based on the Participant's Early Retirement Benefit.

(C) If a Participant dies after becoming eligible for a FAP Disability Benefit (but before his benefit payments commence), then the surviving Spouse shall receive the survivor annuity portion of a 50% joint and survivor annuity that is based on the Participant's FAP Disability Benefit.

(D) If a Participant dies after completing 10 or more years of Credited Service but before reaching age 55, then the surviving Spouse shall receive the survivor annuity portion of a 50% joint and survivor annuity that is based on the Participant's Deferred Vested Benefit that would have been paid once the Participant had attained age 55.

(E) If a Participant dies with a Vested benefit but before completing 10 years of Credited Service, then the surviving Spouse shall receive the survivor annuity portion of a 50% joint and survivor annuity that is based on the Participant's Deferred Vested Benefit that would have been paid once the Participant had attained Normal Retirement Age.

Notwithstanding the foregoing, for all Participants except those Participants who are Former NIFL Employees or Former Kokomo Employees, the monthly survivor death benefit payable to the Spouse pursuant to this subsection (ii) shall not be less than (1) $350, if the FAP Participant had either attained age 65 or attained age 55 and completed 20 or more years of Credited service at the date of his death; or (2) $25 multiplied by the FAP Participant's years of Credited Service up to a maximum of 10 years.

(iii) Commencement. With respect to the death benefit described in this subsection (b), payment shall commence as of the first day of the month following the date of the Participant's death, or if later, as of the first day of the month following the date on which, under the Plan, a Participant could have elected to receive a retirement benefit. Alternatively, a surviving Spouse may elect to defer commencement of the death benefit until the first day of any calendar month preceding or coinciding with the date on which the Participant would have attained Normal Retirement Age, but not later than that date. The monthly amount of any death benefit that commences after the Participant's Earliest Retirement Age shall be increased (as if the Participant had deferred commencement of the benefit) to reflect this deferral.

9.03 Additional Death Benefit Payment Provisions.

(a) Automatic Cash Outs. Notwithstanding anything in this Article to the contrary, if the Actuarial Equivalent present value of any death benefit payable under Section 9.02 is not greater than $5,000, such benefit shall be paid in one lump sum as soon as practicable following the death of the Participant. Such payment shall be in full settlement of the benefit that otherwise would be payable under this Article.

(b) Direct Rollover. In the case of any single sum distribution made under this Article, a surviving Spouse or non-Spouse Beneficiary may elect to have the distribution made in the form of a direct rollover pursuant to Section 10.10.

(c) HEART Act Provision. Notwithstanding anything in this Article to the contrary, in the case of a death occurring on or after January 1, 2007, if a Participant dies while performing qualified military service (as defined in Code Section 414(u)), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the Plan as if the Participant had resumed and then terminated employment on account of death.

9.04 Preretirement Survivor Annuity Requirements. In accordance with Section 9.02(a), if a married AB II Participant or married AB I Participant dies prior to his Benefit Commencement Date, the Plan Administrator shall direct the Trustee to distribute the married Participant's death benefit to the Participant's surviving Spouse as a Preretirement Survivor Annuity, unless a valid waiver election has been made pursuant to this Section 9.04.

(a) Notice Content. The Plan Administrator shall provide each AB II Participant or AB I Participant, within the notice period described in subsection (b), a written explanation of:

(i) the terms and conditions of the automatic Preretirement Survivor Annuity payable under the Plan;

(ii) the Participant's right to make, and the financial consequences of, an election to waive such annuity with respect to his AB I Benefit or AB II Benefit, as applicable;

(iii) the material features and relative values of the automatic and optional preretirement death benefits;

(iv) the rights of the Participant's Spouse regarding a waiver of the automatic Preretirement Survivor Annuity; and

(v) the right of a Participant to revoke a prior waiver of the annuity and the effect and financial consequences of a revocation.

(b) Notice Period. The Plan Administrator shall provide the notice described in subsection (a) within the period beginning on the first day the Participant commences participation in the Plan and ending on the close of the 12-month period following the date on which he becomes an AB I Participant or AB II Participant, as applicable. If a Participant incurs a Termination of Service prior to age 35, the notice shall be provided within one year following the Participant's Termination of Service. If a Participant again becomes an Eligible Employee after a Termination of Service prior to age 35, the Plan Administrator must again provide such notice within the 12-month period after the Participant resumes participation in the Plan as an AB I Participant or AB II Participant, as applicable.

(c) Waiver Procedures.

(i) General Rule. A married Participant who designates a Beneficiary other than his Spouse for the AB I Benefit or AB II Benefit, as applicable, must waive the automatic Preretirement Survivor Annuity in accordance with this Section. A Participant may waive the Preretirement Survivor Annuity, or revoke any such waiver, during the period that begins on the first day the Participant commences participation in the Plan and ends on the date of the Participant's death. The Participant's waiver must be in writing and on a form supplied by the Plan Administrator. The Participant's Spouse must consent in writing to the waiver and must acknowledge the effect and financial consequences of the waiver. The Spouse's consent must be witnessed by a notary public or a Plan representative.

(ii) Election Before Age 35. If a Participant designates a Beneficiary other than his Spouse before the first day of the Plan Year in which the Participant attains age 35, the designation shall become invalid as of the first day of such Plan Year. If the Participant dies on or after that date, any Preretirement Survivor Annuity payable with respect to his AB I Benefit or AB II Benefit, as applicable, shall be payable to the Participant's Spouse unless the Participant makes a new waiver of the automatic Preretirement Survivor Annuity in accordance with this Section on or after the first day of the Plan Year in which he attains age 35.

(iii) Exception to Consent Requirement. The consent of a Participant's Spouse shall not be required where—

(A) the Plan Administrator determines that the required consent cannot be obtained because there is no Spouse or the Spouse cannot be located;

(B) the Plan Administrator determines that the Participant is legally separated;

(C) the Plan Administrator determines that the Participant has been abandoned within the meaning of local law and there is a court order to that effect; or

(D) there exists any other circumstance (as determined by the Plan Administrator) prescribed by law as an exception to the consent requirement.

(iv) Revocation and Modification. A waiver made by a Participant may be revoked by the Participant in writing without the consent of his Spouse at any time during the waiver period. However, any subsequent waiver by a Participant under this Section must comply with the requirements of this Section.

(v) Validity of Spousal Consent. Any consent under this provision shall be valid only with respect to the Spouse who signs the consent or, if the Spouse's consent is excused by the Plan Administrator, the designated Spouse, but shall be irrevocable once given.

9.05 Beneficiary Designation.

Subject to the provisions of this Article and Article X, a Participant may from time to time designate, in writing, any person or persons, contingently or successively, to whom the Trustee shall pay the Participant's death benefit under the Plan. The Plan Administrator shall prescribe the form for the written designation of Beneficiary and, upon the Participant's filing the form with the Plan Administrator, the form effectively shall revoke all designations filed prior to that date by the same Participant.

This Section does not impose any special spousal consent requirements on the Participant's Beneficiary designation. However, in the absence of any required spousal consent (as required by Section 9.04 and Section 10.02) to the Participant's Beneficiary designation: (1) any waiver of the Qualified Joint and Survivor Annuity or of the Preretirement Survivor Annuity is not valid; and (2) if the Participant dies prior to his Benefit Commencement Date and has not designated the Participant's surviving Spouse as the sole, primary Beneficiary under the Beneficiary designation, then the Participant's Beneficiary designation will be invalid.

9.06 Failure of Beneficiary Designation.

If a Participant fails to name a Beneficiary in accordance with Section 9.05, if all Beneficiaries named by a Participant predecease him, or if any designation is not effective for any other reason as determined by the Plan Administrator, then the Participant's death benefit, shall be paid in the following order of priority, to:

(a) the Participant's surviving Spouse;

(b) the Participant's descendants, per stirpes; or

(c) the Participant's estate.

Prior to January 1, 2010, the determination of benefit payments in the event of a failure of a Beneficiary designation shall be made in accordance with the provisions set forth in the Plan 2006 Restatement.

9.07 Facility of Payment.

If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of minority, illness or infirmity, mental incompetency, or incapacity of any kind, the Plan Administrator may, in its discretion, direct the Trustee to take any one or more of the following actions:

(a) To apply such amount directly for the comfort, support and maintenance of such person;

(b) To reimburse any person for any such support theretofore supplied to the person entitled to receive any such payment;

(c) To pay such amount to any person selected by the Plan Administrator to disburse it for such comfort, support and maintenance, including without limitation, any relative who has undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution in whose care or custody the person entitled to the amount may be. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any savings or commercial bank of the Plan Administrator's choice.

(d) To pay any amount to be distributed to or for the benefit of a minor to a custodian named by the Plan Administrator and the Trustee under any Uniform Gifts or Transfers to Minors Act of the state of domicile of such minor, in the manner and form provided thereunder.

ARTICLE X

TIME AND METHOD OF PAYMENT OF BENEFITS

10.01 Automatic Form of Benefit Payment.

Unless a Participant makes a valid waiver election pursuant to Section 10.02 to receive an optional form of benefit under Section 10.03, a Participant shall be paid his benefit determined under Article VII or Article VIII in the form of a "qualified joint and survivor annuity" (the "QJSA"). The QJSA shall in no event be less than the Actuarial Equivalent of the most valuable form of benefit available under the Plan, in accordance with Treasury Regulation Section 1.401(a)-(20).

(a) Unmarried Participants. If, as of the Benefit Commencement Date, the Participant is not married, the automatic form of payment is a Single Life Annuity (for purposes of the waiver requirements of Section 10.02, considered the unmarried participant's QJSA).

(b) Married Participants. The QJSA form of payment for married Participants varies depending on whether an AB II Participant, AB I Participant or FAP Participant as set forth below.

(i) AB II Participants. If, as of the Benefit Commencement Date, the AB II Participant is married, the automatic form of payment is a 50% Joint and Survivor Pop-up Annuity (the married AB II Participant's QJSA). This QJSA provides a monthly benefit to the Participant for his life and, upon the Participant's death, provides an annuity for the life of his surviving Spouse (to whom the Participant was married on his Benefit Commencement Date) in a monthly amount equal to 50% of the amount payable to the Participant during his or her life. In the event that the Spouse dies before the Participant and within 60 months after the Benefit Commencement Date, the amount of the Participant's monthly benefit shall be increased to the amount payable as if the Participant had elected a Single Life Annuity, effective as of the first day of the month following the Spouse's death (the "Pop-up Feature"). The married AB II Participant's QJSA shall be the Actuarial Equivalent of the Single Life Annuity, provided that the retirement benefit to the Participant shall not be reduced to reflect the value of the Pop-up Feature.

(ii) AB I Participants. If, as of the Benefit Commencement Date, the AB I Participant is married, the automatic form of payment is a 50% Joint and Survivor Annuity (the married AB I Participant's QJSA). This QJSA provides a monthly benefit to the Participant for his life and, upon the Participant's death, provides an annuity for the life of his surviving Spouse (to whom the Participant was married on his Benefit Commencement Date) in a monthly amount equal to 50% of the amount payable to the Participant during his or her life. The married AB I Participant's QJSA shall be the Actuarial Equivalent of the Single Life Annuity. The provisions of this Section 10.01(b)(ii) shall not be applicable to the pre-65 supplement described in Section 5.06.

(iii) FAP Participants. If, as of the Benefit Commencement Date, the FAP Participant is married, the automatic form of payment is a 50% Joint and Survivor Annuity (the married FAP Participant's QJSA). This QJSA provides a monthly benefit to the Participant for his life and, upon the Participant's death, provides an annuity for the life of his surviving Spouse (to whom the Participant was married on his Benefit Commencement Date) in a monthly amount equal to 50% of the amount payable to the Participant during his or her life. The married FAP Participant's QJSA shall be the Actuarial Equivalent of the Single Life Annuity.

The reduced amount payable to the FAP Participant shall be determined by multiplying the amount otherwise payable to the FAP Participant pursuant to the provisions of Article VI by the applicable factor in accordance with the provisions of Appendix A. For all Participants except those Participants who are Former NIFL Employees or Former Kokomo Employees, in no event, however, shall the reduced amount payable to a FAP Participant or the 50% survivorship benefit payable to the Spouse of a FAP Participant be less than whichever of the following is applicable: (1) $25.00 multiplied by the Participant's years of Credited Service up to a maximum of ten years, or (2) $350.00 for a Participant (or his Spouse) who is eligible to receive a Normal Retirement Benefit, a FAP Disability Benefit, or an Early Retirement Benefit after 20 or more years of Credited Service. The provisions of this Section 10.01(b)(iii) shall not be applicable to the pre-65 supplement described in Section 6.03 or 7.04(b).

10.02 Waiver Election - Qualified Joint And Survivor Annuity.

(a) Notice. Not earlier than 180 days (90 days, prior to January 1, 2007), but not later than 30 days (or 7 days, if the 30 day period is waived by the Participant), before the Participant's Benefit Commencement Date, the Participant shall be provided with a written explanation of the terms and conditions of the QJSA, the Participant's right to make, and the effect of, an election to waive the automatic QJSA form of benefit, the rights of the Participant's Spouse regarding the waiver election, the Participant's right to make, and the effect of, a revocation of a waiver election, and in accordance with Treasury Regulations Section 1.417(a)-3, a description of the relative values of the various optional forms of benefit under the Plan. In addition, effective January 1, 2007, the notice given to any Participant shall include a description of how much larger benefits will be if the Participant elects to defer the commencement of distributions (if applicable). The Plan does not limit the number of times the Participant may revoke a waiver of the QJSA or make a new waiver during the election period.

(b) Waiver Procedures. Any Participant that receives the notice described in subsection (a) may waive the QJSA and receive one of the optional forms of payment set forth in Section 10.03. The waiver election must be filed with the Plan Administrator within the 180-day period (a 90-day period prior to January 1, 2007) ending on the Participant's Benefit Commencement Date. A married Participant's waiver election is not valid unless (i) the Participant's Spouse (to whom the survivor annuity is payable under the Qualified Joint and Survivor Annuity) has consented in writing to the waiver election; (ii) the election and consent specifies the optional form of benefit elected; (iii) the election and the consent designates a Beneficiary (if applicable); (iv) the Spouse's consent acknowledges the financial consequences of the consent; and (v) a notary public or the Plan Administrator (or its representative) witnesses the Spouse's consent.

(c) Exceptions to Spousal Consent. The consent of the Spouse is not required in the following instances: (i) the Participant elects (if available) the 66 2/3%, 75% (effective January 1, 2008), or 100% contingent annuity option under Section 10.03 with the Spouse as Beneficiary; (ii) the Plan Administrator determines the Participant does not have a Spouse or the Spouse cannot be located; (iii) the Plan Administrator determines that the Participant is legally separated; (iv) the Plan Administrator determines that the Participant has been abandoned within the meaning of the local law and there is a court order to that effect; or (v) there exists any other circumstance (as determined by the Plan Administrator) prescribed by law as an exception to the consent requirement. If the Participant's Spouse is legally incompetent to give consent, the Spouse's legal guardian (even if the guardian is the Participant) may give consent.

(d) Revocation and Modification. An election by a Participant to waive the QJSA may be revoked by the Participant in writing without the consent of his or her Spouse at any time during the election period.

Any subsequent election by a Participant to waive the QJSA or any subsequent modification of a prior election must again comply with the consent requirements of subsection (b), unless the Spouse had previously executed a "blanket consent". The Spouse may execute a blanket consent to any form of payment designation or to any Beneficiary designation made by the Participant, if the blanket consent acknowledges the Spouse's right to limit that consent to a specific designation but, in writing, waives such right.

10.03 Optional Forms of Benefit Distribution. Subject to the waiver requirements of Section 10.02, the small benefit provisions of Section 10.04, and the minimum distribution provisions of Section 10.07, a Participant may elect to receive his benefit in the form of an optional method of payment set forth in this Section. Each optional form of payment shall be the Actuarial Equivalent of the applicable retirement benefit described in Article VII or the Deferred Vested Benefit described in Section 8.01. The election of an optional form of payment shall be in writing in the manner prescribed by the Plan Administrator, and, if in accordance with the conditions set forth below, shall become effective as of his Benefit Commencement Date. The election of an optional form of payment (or the automatic payment of the QJSA by default) cannot be revoked or changed once it has become effective.

The optional forms of payment under this Section vary depending on whether the Participant is an AB II Participant, AB I Participant, or FAP Participant as set forth below.

(a) AB II Participant and AB I Participants.

(i) Lump Sum Option – A single lump sum payment with no additional amounts after such payment if made.

(ii) Single Life Annuity Option – A monthly benefit payable to the Participant, with payments ending on the Participant's death.

(iii) 50% Joint and Survivor Pop-up Annuity Option. A reduced monthly benefit payable to the Participant (further reduced to reflect the value of the Pop-up Feature when not the AB II Participant's QJSA) for the life of the Participant, with continuation payments as a survivor annuity for the remaining life of the Beneficiary at a rate of 50% of the rate payable during the Participant's lifetime. In the event that the Beneficiary dies before the Participant, and within 60 months after the Benefit Commencement Date, the amount of the Participant's monthly benefit shall be increased to the amount payable as if the Participant had elected a Single Life Annuity, effective as of the first day of the month following the Beneficiary's death.

(iv) Joint and Survivor Annuity Options - A reduced monthly benefit payable to the Participant for life and to a surviving designated Beneficiary for the lifetime of the Beneficiary in an amount equal to 33 1/3%, 66 2/3%, 50% (with respect to AB I Participants only), 75% (effective January 1, 2008) or 100% (as elected by the Participant) of the rate payable during the Participant's lifetime.

(v) Five or Ten Year Certain and Life Annuity Option. A reduced monthly pension payable to the Participant for his life, but in the event the Participant dies before receiving 60 or 120 monthly payments, whichever number is specified in his election of this option, such payments shall continue to his Beneficiary for the balance of such 60 or 120 month period.

(b) FAP Participants.

(i) Single Life Annuity Option – A monthly benefit payable to the Participant, with payments ending on the Participant's death.

(ii) Joint and Survivor Annuity Options - A reduced monthly benefit payable to the Participant for life and to a surviving designated Beneficiary for the lifetime of the Beneficiary in an amount equal to 50% (the QJSA for a married Participant and an optional form for an unmarried Participant), 75% or 100% (as elected by the Participant) of the rate payable during the Participant's lifetime.

If a FAP Participant elects the 75% or 100% Joint and Survivor Option, the reduced annuity benefit payable to the Participant shall be based on the FAP Participant's Normal Retirement Benefit and the applicable factor in accordance with the provisions of Appendix A. For all Participants except those Participants who are Former NIFL Employees or Former Kokomo Employees, in no event, however, shall the reduced amount payable to a FAP Participant or the survivorship benefit payable to the Spouse of a FAP Participant be less than whichever of the following is applicable: (1) $25.00 multiplied by the Participant's years of Credited Service up to a maximum of ten years, or (2) $350.00 for a Participant (or his Spouse) who is eligible to receive a Normal Retirement Benefit, a FAP Disability Benefit, or an Early Retirement Benefit after 20 or more years of Credited Service.

(iii) Special Provisions for Former NIFL Employees. A FAP Participant who is a Former NIFL Employee may elect to receive the portion of his annuity benefit attributable to his benefit accrued under the NIFL Prior Plan in one of the additional optional forms described below:

(A) A monthly income payable for the Participant's lifetime with either 60, 120, 180 or 240 monthly payments guaranteed, as selected by the Participant.

(B) With no lifetime guarantee, a monthly income payable for a guaranteed number of payments equal to 60, 120, 180 or 240 monthly payments, as selected by the Participant.

In the event of a Participant's death before payment of the guaranteed number of payments set forth in Sections A or B above, the remaining payments shall be paid to his beneficiary designated by the Participant by written instrument most recently delivered to the Plan Administrator prior to his death.

(C) A monthly income payable for the lifetime of the Participant and continuing thereafter in an amount of 50%, 66-2/3% or 75%, or equally as great, as elected by the Participant, to a beneficiary designated in writing by the Participant by written instrument most recently delivered to the Plan Administrator prior to his death. Should the beneficiary named by the Participant die prior to the commencement of benefits, the election shall be void and a monthly annuity benefit shall be paid under the automatic form designated in Section 10.01, unless an alternative election is made pursuant to this Section. Should the beneficiary die after monthly annuity payments have commenced to the Participant, no alternative beneficiary can be named.

(D) A lump sum payment to the Participant, but only at his actual date of retirement, equal to the actuarial equivalent of the monthly annuity payable over the Participant's lifetime with 120 monthly payments guaranteed.

If the Participant's designated beneficiary is other than his Eligible Spouse, the Actuarial Equivalent of the benefits payable to the Participant shall be more than 50% of the Actuarial Equivalent of the benefits payable to the Participant and his beneficiary or survivor.

(iv) Special Provisions for Former Kokomo Employees. A FAP Participant who is a Former Kokomo Employee may elect to receive the portion of his annuity benefit attributable to his benefit accrued under the Kokomo Prior Plan in one of the additional optional forms described below:

(A) A monthly annuity payable during the Participant's lifetime in an adjusted level monthly amount with provision for continuing level monthly payments of a specified percentage equal to 50%, 66-2/3%, 75% (effective January 1, 2008) or 100%, as selected by the Participant, of such adjusted monthly amount for the lifetime of the Participant's beneficiary (designated by written instrument most recently delivered to the Plan Administrator prior to death); provided, however, if the beneficiary is other than the Participant's Eligible Spouse, the present value of payments expected to be made to the Participant must exceed 50% of the present value of the total payments expected to be made to the Participant and his beneficiary; or

(B) A monthly annuity payable during the Participant's lifetime in an adjusted level monthly amount with a guaranteed minimum number of monthly payments equal to 120, 180 or 240, as selected by the Participant, subject to the right of the Committee upon the death of the Participant to distribute the commuted value of the remaining payments, if any, to the beneficiary in final satisfaction of the benefit; provided, however, if the beneficiary is other than the Participant's Eligible Spouse, the present value of payments expected to be made to the Participant must exceed 50% of the present value of the total payments expected to be made to the Participant and his beneficiary; and further provided that the number of guaranteed monthly payments shall not extend for a period greater than the joint life expectancy of the Participant and his Eligible Spouse, if any (with such life expectancy determined as of the date that benefit payments commence in accordance with Treasury Regulations).

(v) The optional forms described in paragraphs (iii) and (iv) above shall be determined pursuant to the actuarial factors used by the NIFL Prior Plan or the Kokomo Prior Plan, as applicable.

10.04 Cash Out of Small Amounts.

Except as otherwise provided, all benefits under the Plan shall be payable in accordance with the provisions of this Article X. Furthermore, notwithstanding any provision to the contrary, the Participant must consent in writing to any distribution and to the form of distribution if: (1) the benefit payable to the Participant exceeds $5,000 and (2) the Plan Administrator directs the Trustee to make distribution to the Participant prior to his attaining Normal Retirement Age. Furthermore, the Participant's Spouse must consent in writing to the distribution if the Participant must consent.

Notwithstanding anything in this Article X to the contrary, if the Actuarial Equivalent of the benefit payable to the Participant is not greater than $5,000, the benefit shall be paid to the Participant in a lump sum as soon as practicable following the Participant's Benefit Commencement Date. Effective March 28, 2005, if the single lump sum Actuarial Equivalent of the benefit payable to a Participant exceeds $1,000, but does not exceed $5,000, and the Participant does not elect to have such distribution paid directly to the Participant or in the

form of a direct rollover in accordance with Section 10.10, then the Plan Administrator shall pay the distribution in a direct rollover to an individual retirement plan designated by the Plan Administrator.

10.05 Claim for Benefits.

Except as provided under Article IX and Section 10.04, no benefits shall be paid under the Plan unless the Participant entitled thereto submits to the Plan, in a form prescribed by the Plan Administrator, all of the information reasonably necessary for the payment of such benefits.

10.06 Restrictions on Distribution Timing. Notwithstanding anything in this Article to the contrary, unless the Participant otherwise elects in writing, distribution to the Participant shall not commence later than the sixtieth day after the close of the Plan Year in which occurs the latest of the following events:

(a) the Participant attains age 65;

(b) the Participant attains the tenth anniversary of the date on which he became a Participant under the Plan; or

(c) the Participant incurs a Termination of Service.

Notwithstanding the foregoing, the failure of a Participant and Spouse to consent to a distribution while a benefit is immediately distributable shall be deemed to be an election to defer commencement of payment of any benefit sufficient to satisfy this Section.

10.07 Minimum Distribution Requirements.

(a) General Rules.

(i) Precedence and Effective Date. The requirements of this Section shall take precedence over any inconsistent provisions of the Plan. This provisions of this Section will apply for purposes of determining required minimum distributions for calendar years beginning with the 2003 calendar year.

(ii) Requirements of Treasury Regulations Incorporated. All distributions required under this Section shall be determined and made in accordance with the Treasury Regulations under Code Section 401(a)(9).

(iii) Limitations on Distribution Periods. As of the first Distribution Calendar Year, distributions to a Participant, if not made in a single lump sum, may only be made over one of the following periods:

(A) the life of the Participant;

(B) the joint lives of the Participant and a Designated Beneficiary;

(C) a period certain not extending beyond the life expectancy of the Participant; or

(D) a period certain not extending beyond the joint life and last survivor expectancy of the Participant and a Designated Beneficiary.

(b) Time and Manner of Distribution.

(i) Required Beginning Date. The Participant's entire interest shall be distributed, or begin to be distributed, to the Participant no later than the Participant's Required Beginning Date.

(ii) Death of Participant Before Distributions Begin. If the Participant dies before distributions begin, the Participant's entire interest shall be distributed, or begin to be distributed, no later than as follows:

(A) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, distributions to the Spouse shall begin by December 31 of the calendar year immediately following the calendar year in which the Participant died, or by December 31 of the calendar year in which the Participant would have attained age 70-1/2, if later.

(B) If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, distributions to the Designated Beneficiary shall begin by December 31 of the calendar year immediately following the calendar year in which the Participant died.

(C) If there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, the Participant's entire interest shall be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(D) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary and the Spouse dies after the Participant but before distributions to the Spouse begin, this subsection (b)(ii), other than subsection (b)(ii)(A), shall apply as if the Spouse were the Participant.

For purposes of this subsection (b)(ii) and subsection (e)(ii), distributions are considered to begin on the Participant's Required Beginning Date (or, if subsection (b)(ii)(D) applies, the date distributions are required to begin to the Spouse under subsection (b)(ii)(A)). If annuity payments irrevocably commence to the Participant before the Participant's Required Beginning Date (or to the Participant's Spouse before the date distributions are required to begin to the Spouse under subsection (b)(ii)(A)), the date distributions are considered to begin is the date distributions actually commence.

(iii) Form of Distribution. Unless the Participant's interest is distributed in the form of an annuity purchased from an insurance company or in a single sum on or before the Required Beginning Date, as of the first Distribution Calendar Year, distributions shall be made in accordance with paragraphs (c), (d) and (e) of this Section. If the Participant's interest is distributed in the form of an annuity purchased from an insurance company, distributions thereunder shall be made in accordance with the requirements of Code Section 401(a)(9) and the regulations thereunder. Any part of the Participant's interest which is in the form of an individual account described in Code Section 414(k) shall be distributed in a manner satisfying the requirements of Code Section 401(a)(9) and the Treasury Regulations thereunder that apply to individual accounts.

(c) Determination of Amount to be Distributed Each Year.

(i) General Annuity Requirements. If the Participant's interest is paid in the form of annuity distributions under the Plan, payments under the annuity shall satisfy the following requirements:

(A) the annuity distributions shall be paid in periodic payments made at intervals not longer than one year;

(B) the distribution period shall be over a life (or lives) or over a period certain not longer than the period described in subsection (d) or (e);

(C) once payments have begun over a period certain, the period certain shall not be changed even if the period certain is shorter than the maximum permitted;

(D) payments shall either be nonincreasing or may increase only as follows:

1. by an annual percentage increase that does not exceed the annual percentage increase in a Eligible Cost-of-Living Index that is based on prices of all items and issued by the Bureau of Labor Statistics;

2. by a constant percentage of less than 5% per year, applied not less frequently than annually;

3. as a result of dividend or other payments that result from Actuarial Gains, in accordance with Treasury Regulations Section 1.401(a)(9)-6, Q&A-14(d)(3);

4. to the extent of the reduction in the amount of the Participant's payments to provide for a survivor benefit upon death, but only if the beneficiary whose life was being used to determine the distribution period described in subsection (d) below dies or is no longer the Participant's beneficiary pursuant to a qualified domestic relations order within the meaning of Code Section 414(p);

5. to provide final payment upon the Participant's death not greater than the excess of the actuarial present value of the Participant's accrued benefit (within the meaning of Code Section 411(a)(7)) calculated as of the annuity starting date using the applicable interest rate defined in Section 1.08 and the applicable mortality table defined in Section 1.08 (or, if greater, the total amount of employee contributions) over the total payments before the Participant's death;

6. to allow a beneficiary to convert the survivor portion of a joint and survivor annuity into a single sum distribution upon the Participant's death; or

7. to pay increased benefits that result from a Plan amendment.

(ii) Amount Required to be Distributed by Required Beginning Date. The amount that must be distributed on or before the Participant's Required Beginning Date (or, if the Participant dies before distributions begin, the date distributions are required to begin under subsection (b)(ii)(A) or (b)(ii)(B)) is the payment that is required for one payment interval.

The second payment need not be made until the end of the next payment interval even if that payment interval ends in the next calendar year. Payment intervals are the periods for which payments are received (*e.g.*, bi-monthly, monthly, semi-annually, or annually). All of the Participant's benefit accruals as of the last day of the first Distribution Calendar Year shall be included in the calculation of the amount of the annuity payments for payment intervals ending on or after the Participant's Required Beginning Date.

(iii) Additional Accruals After First Distribution Calendar Year. Any additional benefits accruing to the Participant in a calendar year after the first Distribution Calendar Year shall be distributed beginning with the first payment interval ending in the calendar year immediately following the calendar year in which such amount accrues.

(d) Requirements For Annuity Distributions That Commence During Participant's Lifetime.

(i) Joint Life Annuities Where the Beneficiary Is Not the Participant's Spouse. If the Participant's interest is being distributed in the form of a joint and survivor annuity for the joint lives of the Participant and a non-Spouse beneficiary, annuity payments to be made on or after the Participant's Required Beginning Date to the Designated Beneficiary after the Participant's death must not at any time exceed the applicable percentage of the annuity payment for such period that would have been payable to the Participant using the table set forth in Treasury Regulation Section 1.401(a)(9)-6, Q&A-2(c)(2), in the manner described in Q&A-2(c)(1), to determine the applicable percentage. If the form of distribution combines a joint and survivor annuity for the joint lives of the Participant and a non-Spouse beneficiary and a period certain annuity, the requirement in the preceding sentence shall apply to annuity payments to be made to the Designated Beneficiary after the expiration of the period certain.

(ii) Period Certain Annuities. Unless the Participant's Spouse is the sole Designated Beneficiary and the form of distribution is a period certain and no life annuity, the period certain for an annuity distribution commencing during the Participant's lifetime may not exceed the applicable distribution period for the Participant under the Uniform Lifetime Table set forth in Treasury Regulation Section 1.401(a)(9)-9, Q&A-2 for the calendar year that contains the annuity starting date. If the annuity starting date precedes the year in which the Participant reaches age 70, the applicable distribution period for the Participant is the distribution period for age 70 under the Uniform Lifetime Table set forth in Treasury Regulation Section 1.401(a)(9)-9, Q&A-2 plus the excess of 70 over the age of the Participant as of the Participant's birthday in the year that contains the annuity starting date. If the Participant's Spouse is the Participant's sole Designated Beneficiary and the form of distribution is a period certain and no life annuity, the period certain may not exceed the longer of the Participant's applicable distribution period, as determined under this subsection (d)(ii), or the joint life and last survivor expectancy of the Participant and the Participant's Spouse as determined under the Joint and Last Survivor Table set forth in Treasury Regulation Section 1.401(a)(9)-9, Q&A-3, using the Participant's and Spouse's attained ages as of the Participant's and Spouse's birthdays in the calendar year that contains the annuity starting date.

(e) Requirements for Minimum Distributions After the Participant's Death.

(i) Death After Distributions Begin. If the Participant dies after distribution of his or her interest begins in the form of an annuity meeting the requirements of this Section, the remaining portion of the Participant's interest will continue to be distributed over the remaining period over which distributions commenced.

(ii) Death Before Distributions Begin.

(A) Participant Survived by Designated Beneficiary. If the Participant dies before the date distribution of his interest begins and there is a Designated Beneficiary, the Participant's entire interest shall be distributed, beginning no later than the time described in subsection (b)(ii)(A) or (b)(ii)(B), over the life of the Designated Beneficiary or over a period certain not exceeding:

1. unless the annuity starting date is before the first Distribution Calendar Year, the life expectancy of the Designated Beneficiary determined using the Designated Beneficiary's age as of the Designated Beneficiary's birthday in the calendar year immediately following the calendar year of the Participant's death; or

2. if the annuity starting date is before the first Distribution Calendar Year, the life expectancy of the Designated Beneficiary determined using the Designated Beneficiary's age as of the Designated Beneficiary's birthday in the calendar year that contains the annuity starting date.

(B) No Designated Beneficiary. If the Participant dies before the date distributions begin and there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, distribution of the Participant's entire interest shall be completed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(C) Death of Surviving Spouse Before Distributions to Surviving Spouse Begin. If the Participant dies before the date distribution of his interest begins, the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, and the surviving Spouse dies before distributions to the surviving Spouse begin, this subsection (e) shall apply as if the surviving Spouse were the Participant, except that the time by which distributions must begin shall be determined without regard to subsection (b)(ii)(A).

(f) Changes to Annuity Payment Period.

(i) Permitted Changes. An annuity payment period may be changed only in association with any annuity payment increase described in Section 10.07(c)(i)(D) above or if the conditions of Section 10.07(f)(iii) below are satisfied.

(ii) Reannuitization. An annuity payment period may be changed and the annuity payments modified in accordance with that change if the conditions in Section 10.07(f)(iii) below are satisfied and:

(A) the modification occurs when the Participant retires or in connection with a Plan termination;

(B) the payment period prior to modification is a period certain without life contingencies; or

(C) the annuity payments after modification are paid under a qualified joint and survivor annuity over the joint lives of the Participant and a Designated Beneficiary, the

Participant's Spouse is the sole Designated Beneficiary, and the modification occurs in connection with the Participant's becoming married to such Spouse.

(iii) Conditions. The conditions of this Section 10.07(f) are satisfied if:

(A) the future payments after the modification satisfy the requirements of Code Section 401(a)(9), and this Section (determined by treating the date of the changes as a new annuity starting date and the actuarial present value of the remaining payments prior to modification as the entire interest of the Participant);

(B) for purposes of Code Sections 415 and 417, the modification is treated as a new annuity starting date;

(C) after taking into account the modification, the annuity (including all past and future payments) satisfies the requirements of Code Section 415 (determined at the original annuity starting date, using the interest rates and mortality tables applicable to such date); and

(D) the end point of the period certain, if any, for any modified payment period is not later than the end point available to the employee at the original annuity starting date under Code Section 401(a)(9) and this Section.

(g) Payments to a Surviving Child.

(i) Special rule. For purposes of this Section, payments made to a Participant's surviving child until the child reaches the age of majority (or dies, if earlier) shall be treated as if such payments were made to the surviving Spouse to the extent the payments become payable to the surviving Spouse upon cessation of the payment to the child.

(ii) Age of Majority. For purposes of this Section, a child shall be treated as having not reached the age of majority if the child has not completed a specified course of education and is under the age of 26. In addition, a child who is disabled within the meaning of Code Section 72(m)(7) when the child reaches the age of majority shall be treated as having not reached the age of majority so long as the child continues to be disabled.

(h) Definitions.

(i) Actuarial Gain. The difference between an amount determined using the actuarial assumptions (i.e., investment return, mortality, expense and other similar assumptions) used to calculate the initial payments before adjustment for any increases and the amount determined under the actual experience with respect to those factors. Actuarial Gain also includes differences between the amount determined using actuarial assumptions when an annuity was purchased or commenced and such amount determined using actuarial assumptions used in calculating payments at the time the Actuarial Gain is determined.

(ii) Designated Beneficiary. The individual who is designated as the beneficiary under the Plan and is the Designated Beneficiary under Code Section 401(a)(9) and Treasury Regulation Section 1.401(a)(9)-4.

(iii) Distribution Calendar Year. A calendar year for which a minimum distribution is required. For distributions beginning before the Participant's death, the first Distribution Calendar Year

is the calendar year immediately preceding the calendar year that contains the Participant's Required Beginning Date. For distributions beginning after the Participant's death, the first Distribution Calendar Year is the calendar year in which distributions are required to begin pursuant to subsection 10.07(b).

(iv) Eligible Cost-of –Living Index. An index described in paragraphs (b)(2), (b)(3) or (b)(4) of Treasury Regulation Section 1.401(a)(9)-6, Q&A-14.

(v) Life Expectancy. For purposes of this Section, life expectancy shall be computed by using the Single Life Table in Treasury Regulation Section 1.401(a)(9)-9, Q&A-1.

(vi) Required Beginning Date. For purposes of this Section, April 1 of the calendar year following the later of the calendar year in which the Participant (1) attains age 70-1/2, or (2) terminates employment with the Company, unless he is a five percent owner (as defined in Code Section 416) at any time during the Plan Year ending with or within the calendar year in which he attains age 70-1/2, in which case clause (2) shall not apply.

Except with respect to a 5-percent owner, a Participant's accrued benefit will be actuarially increased to take into account the period after age 70-1/2 in which the Participant does not receive any benefits under the plan. The actuarial increase will begin on April 1 following the calendar year in which the employee attains age 70-1/2 (January 1, 1997 in the case of an employee who attains age 70'/ prior to 1996), and will end on the date on which benefits commence after retirement in an amount sufficient to satisfy Code Section 401(a)(9). The amount of actuarial increase payable as of the end of the period for actuarial increases will be no less than the actuarial equivalent of the Participant's retirement benefits that would have been payable as of the date the actuarial increase must commence plus the actuarial equivalent of additional benefits accrued after that date, reduced by the actuarial equivalent of any distributions made after that date. The actuarial increase under this Section is not in addition to the actuarial increase required for that same period under Code Section 411 to reflect the delay in payments after normal retirement, except that the actuarial increase required under this Section will be provided even during the period during which an employee is in ERISA Section 203(a)(3)(B) service. For purposes of Code Section 411(b)(1)(H), the actuarial increase will be treated as an adjustment attributable to the delay in distribution of benefits after the attainment of normal retirement age. Accordingly, to the extent permitted under Code Section 411(b)(1)(H), the actuarial increase required under this Section will reduce the benefit accrual otherwise required under Code Section 411(b)(1)(H)(i), except that the rules on the suspension of benefits are not applicable.

(vii) Five Percent Owner. A Participant is treated as a five percent owner for purposes of this Section if the Participant is a five percent owner as defined in Code Section 416 at any time during the Plan Year ending with or within the calendar year in which such owner attains age 70 ½ . Once distributions have begun to a five percent owner under this Section, they must continue to be distributed, event if the Participant ceases to be a five percent owner in a subsequent year.

10.08 Purchase Of Nontransferable Annuity.

In general, the Trustee shall make payment of any pension directly to the Participant entitled to the payment. However, the Committee may instruct the Trustee to purchase a Nontransferable Annuity contract from an insurance company. A "Nontransferable Annuity" is an annuity which by its terms provides that it may not be sold, assigned, discounted, pledged as collateral for a loan or security for the performance of an obligation or

for any other purpose, to any person other than the insurance company which issued it. If the Plan distributes an annuity contract, the contract must be a Nontransferable Annuity.

The Nontransferable Annuity contract must provide pension and other benefits in an amount not less than the pension and other benefits a Participant would receive under this Plan and otherwise must comply with the requirements of this Plan. In the event the Trustee purchases a Nontransferable Annuity contract for the benefit of a Participant, the Trustee may either assign the contract to the Participant or hold the contract for the benefit of the Participant pursuant to the instructions of the Committee. The Trustee also may purchase a Nontransferable Annuity contract for the benefit of a designated Beneficiary, surviving Spouse, or alternate payee under a qualified domestic relations order (as defined in Code Section 414(p)) entitled to distribution of all or a portion of the Participant's Vested Accrued Benefit.

10.09 Qualified Domestic Relations Order.

This Plan shall comply with the provisions of a qualified domestic relations order ("QDRO") (as defined in Code Section 414(p)). The Plan shall calculate the alternate payee's benefit pursuant to a QDRO as if the Participant had retired on the date on which such payment is to begin under such order (but taking into account only the present value of the benefits actually accrued and not taking into account the present value of any Employer subsidy for early retirement). If the Actuarial Equivalent of the alternate payee's benefits under the Plan is less than or equal to $5,000, the Trustee shall distribute such alternate payee's benefit in the form of a single lump sum as soon as administratively practicable after the qualified status of the QDRO has been confirmed. Effective on or after April 6, 2007, a domestic relations order that otherwise satisfies the requirement for a QDRO will not fail to be a QDRO: (1) solely because the order is issued after, or revises, another domestic relations order or QDRO; or (2) solely because of the time at which the order is issued, including issuance after the Benefit Commencement Date or after the Participant's death. A domestic relations order described in the foregoing sentence is subject to the same requirements and protections that apply to QDRO's. Distribution to an alternate payee under a QDRO shall not be made prior to the date the Participant has attained his "earliest retirement age" under the Plan as defined in Code Section 414(p). Nothing in this Section gives a Participant the right to receive a distribution at a time not permitted under the Plan, nor does this Section give the alternate payee the right to receive a form of payment not permitted under the Plan.

For purposes of this Article X, a former Spouse who is an alternate payee under a QDRO shall be treated as the Participant's Spouse or surviving Spouse to the extent provided under the QDRO. The survivor annuity requirements and the joint and survivor annuity requirements apply separately to the portion of the Participant's Vested Accrued Benefit subject to the QDRO and to the portion of the Participant's Vested Accrued Benefit not subject to such order.

Reasonable procedures shall be established to determine the qualified status of a domestic relations order. Upon receiving a domestic relations order, the Plan Administrator shall promptly notify the Participant and any alternate payee named in the order, in writing, of the receipt of the order and the Plan's procedures for determining the qualified status of the order. Within a reasonable period of time after receiving the domestic relations order, the Plan Administrator shall determine the qualified status of the order and notify the Participant and each alternate payee, in writing, of its determination. The notices required under this paragraph shall be provided by the Plan Administrator by mailing such notices to the individuals, at the addresses specified in the domestic relations order, or in a manner consistent with Department of Labor Regulations.

If any portion of the Participant's Vested Accrued Benefit is payable during the period the Plan Administrator is making its determination of the qualified status of the domestic relations order, the Plan Administrator shall make a separate accounting of the amounts payable. If the Plan Administrator determines the order is a QDRO within eighteen (18) months of the date any such amounts are first payable following receipt of the

order, the Plan Administrator shall direct the Trustee to distribute the payable amounts in accordance with the order. If the Plan Administrator does not make its determination of the qualified status of the order within the 18-month determination period, the payable amounts shall be distributed in the manner the Plan would distribute if the order did not exist and shall apply the order prospectively if it is later determined that the order is a QDRO.

10.10 Direct Rollovers.

(a) General Rule. Notwithstanding any provision of the Plan to the contrary that would otherwise limit a Distributee's election under this Section, a Distributee may elect, at the time and in the manner prescribed by the Plan Administrator, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover. The Plan Administrator may establish rules and procedures governing the processing of Direct Rollovers and limiting the amount or number of such Direct Rollovers in accordance with applicable Treasury Regulations. Distributions not transferred to an Eligible Retirement Plan in a Direct Rollover shall be subject to income tax withholding as provided under the Code and applicable state and local laws, if any.

(b) Definitions:

(i) "Eligible Rollover Distribution" – An Eligible Rollover Distribution is any distribution of all or any portion of the balance to the credit of the Distributee, except that an Eligible Rollover Distribution does not include: (i) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and the Distributee's designated Beneficiary, or for a specified period of ten years or more; (ii) any distribution to the extent such distribution is required under Code Section 401(a)(9); (iii) the portion of any distribution that is not includable in gross income (determined without regard to the exclusion for net unrealized appreciation with respect to employer securities); and (iv) any hardship distribution described in Code Section 401(k)(2)(B)(i)(IV) or Section 403(b)(11)(B).

(ii) "Eligible Retirement Plan" - An eligible retirement plan is an individual retirement account described in Code Section 408(a), an individual retirement annuity described in Code Section 408(b), an annuity plan described in Code Section 403(a), a qualified trust described in Code Section 401(a), a tax sheltered annuity plan described in Code Section 403(b) or an eligible deferred compensation plan described in Code Section 457(b) that is maintained by an eligible employer described in Code Section 457(e)(1)(A) that agrees to separately account for amounts transferred into such plan that accepts the distributee's eligible rollover distribution. The definition of eligible retirement plan shall also apply in the case of a distribution to the Employee's or former Employee's surviving Spouse or the Employee's or former Employee's Spouse or former Spouse who is the alternate payee under a qualified domestic relations order, as defined in Code Section 414(p). Effective May 1, 2007, the definition of "Eligible Retirement Plan" also shall apply in the case of a distribution to an individual retirement account described in Code Section 408(a) or individual retirement annuity described in Code Section 408(b) established for the purpose of receiving such distribution on behalf of a non-Spouse beneficiary of the Employee. For distributions made after December 31, 2007 to any Distributee (Participant or Beneficiary), an "Eligible Retirement Plan" shall include a Roth IRA described in Code Section 408A(b).

(iii) "Distributee" - A Distributee includes an Employee or former Employee. In addition, the Employee's or former Employee's surviving Spouse and the Employee's or former Employee's

Spouse or former Spouse who is the alternate payee under a qualified domestic relations order, as defined in Code Section 414(p), are Distributees with regard to the interest of the Spouse or former Spouse. Effective May 1, 2007, the Employee's non-Spouse beneficiary also is a Distributee, but only for distributions to individual retirement accounts described in Code Section 408(a) or individual retirement annuities described in Code Section 408(b), as provided in Section 10.10(b)(ii) of the Plan.

(iv) "Direct Rollover" - A Direct Rollover is a payment by the Plan to the Eligible Retirement Plan specified by the distributee.

(c) Special Rules Pertaining to Non-Spouse Beneficiary Rollover Right. For distributions on or after May 1, 2007, a non-Spouse beneficiary who is a "designated beneficiary" under Code Section 401(a)(9)(E) and the regulations thereunder, by a direct trustee-to-trustee transfer ("direct rollover"), may roll over all or any portion of his/her distribution to an individual retirement account/annuity the beneficiary establishes for purposes of receiving the distribution. In order to be able to roll over the distribution, the distribution otherwise must satisfy the definition of an eligible rollover distribution.

(i) Certain requirements not applicable. Although a non-Spouse beneficiary may roll over directly a distribution as provided in this Section 10.10, the distribution, if made prior to January 1, 2010, is not subject to the direct rollover requirements of Code Section 401(a)(31), the notice requirements of Code Section 402(f) or the mandatory withholding requirements of Code Section 3405(c). If a non-Spouse beneficiary receives a distribution from the Plan, the distribution is not eligible for a "60-day" rollover.

(ii) Trust Beneficiary. If the Participant's named beneficiary is a trust, the Plan may make a direct rollover to an individual retirement account/annuity on behalf of the trust, provided the trust satisfies the requirements to be a designated beneficiary within the meaning of Code Section 401(a)(9)(E).

(iii) Required Minimum Distributions Not Eligible for Rollover. A non-Spouse beneficiary may not roll over an amount which is a required minimum distribution, as determined under applicable Treasury regulations and other Internal Revenue Service guidance. If the Participant dies before his/her required beginning date and the non-Spouse beneficiary rolls over to an IRA the maximum amount eligible for rollover, the beneficiary may elect to use either the 5-year rule or the life expectancy rule, pursuant to Treas. Reg. Section 1.401(a)(9)-3, A-4(c), in determining the required minimum distributions from the IRA that receives the non-Spouse beneficiary's distribution.

10.11 True-Up Amounts. Except as otherwise provided in the Plan, any additional amounts the Plan Administrator determines a Participant to be entitled to after his benefit payments commence ("True-Up Amounts") shall be paid in a single sum as soon as administratively feasible after such determination is made and shall include appropriate adjustments, as determined by the Plan Administrator, for interest from the date the benefit payments commenced to the date payment of the True-Up Amounts is made. For purposes of this Section, interest shall be determined in accordance with Section 10.12(c).

10.12 Retroactive Annuity Starting Date.

(a) Notwithstanding anything contained in the Plan to the contrary, with respect to a Participant who receives the notices and explanations described in Sections 9.04 and 10.02, the Plan may provide a Participant's benefit based on his Retroactive Annuity Starting Date if the following requirements are satisfied:

(i) The Plan Administrator provides the written notices and explanations described in Sections 9.04 and 10.02 either:

(A) between 30 days and 180 days (90 days prior to January 1, 2007) before the date of the Participant's receipt of his first benefit payment based on his Retroactive Annuity Starting Date, or

(B) less than 30 days before the date of receipt of the Participant's first benefit payment based on his Retroactive Annuity Starting Date if the date of such payment is after the date such notices and explanations are provided to the Participant, the Participant affirmatively elects a form of distribution, and his Spouse consents, if necessary, pursuant to Section 10.02;

provided, however, that the Plan will not fail to satisfy the requirement of subparagraph (A) due solely to administrative delay that results in the commencement of benefits after the 180 days (90 days prior to January 1, 2007) described above;

(ii) The Participant affirmatively elects, at the time and in the manner specified by the Plan Administrator, to use the Retroactive Annuity Starting Date, and such election is made after the written notices and explanations described in paragraph (i) above are provided and on or before the date the Participant's first benefit payment is made;

(iii) The Participant's future periodic benefit payments based on the Retroactive Annuity Starting Date, if any, are the same as the periodic benefit payments that would have been paid to the Participant had payment actually commenced on the Retroactive Annuity Starting Date;

(iv) The Participant receives a make-up amount in a single sum, as determined by the Plan Administrator, to reflect any missed payment(s) due to the use of a Retroactive Annuity Starting Date (with appropriate adjustments, as determined by the Plan Administrator, for interest from the date the payments would have been made to the date benefit payments actually commence) as soon as administratively feasible after the make-up amount is determined;

(v) The Participant's Spouse, determined as of the date benefit payments actually commence, consents to the distribution of the make-up amount to the Participant in a manner that would satisfy the applicable consent requirements of Sections 9.04 and 10.02; provided, however, that this paragraph (v) shall not apply if the amount of the Spouse's survivor annuity payments under the Retroactive Annuity Starting Date election would be no less than the amount that the survivor payments to such Spouse would have been under a Qualified Joint and Survivor Annuity and that has an annuity starting date after the date that the notice and explanation described in subsection 9.04 was provided;

(vi) The benefit (including appropriate interest adjustments, as determined by the Plan Administrator) provided based on the Participant's Retroactive Annuity Starting Date would satisfy the requirements of Code Section 415 if the date the payments commence is substituted for the annuity starting date for all purposes, including for purposes of determining the applicable interest rate and mortality table; provided, however, that the requirement to apply Code Section 415 as of the date payments commence shall not apply in the case of a form of benefit that would have been excepted from the present value requirements of Treasury Regulation Section 1.417(e)-1(d)(6) if the distribution had actually commenced on the

Retroactive Annuity Starting Date, if the date distribution commences is 12 months or less from the Retroactive Annuity Starting Date; and

(vii) In the case of a form of benefit that would have been subject to Code Section 417(e)(3) and Treasury Regulation Section 1.417(e)-1(d) if payments had commenced as of the Retroactive Annuity Starting Date, the distribution is no less than the benefit produced by applying the Applicable Interest Rate and Applicable Mortality Table (as described under Code Section 417(e)(3)) determined as of the date the payments commence to the annuity form that corresponds to the annuity form that was used to determine the benefit amount as of the Retroactive Annuity Starting Date.

(b) For purposes of this Section, "Retroactive Annuity Starting Date" means the date a Participant's annuity benefit should commence that is on or before the date the written explanations described in Sections 9.04 and 10.02 are provided to such Participant; provided, however, that such date shall not be earlier than the date upon which the Participant could have otherwise started receiving his benefit.

(c) For purposes of this Section, interest shall be determined using the interest rate applicable to a lump sum payment under Section 1.08 for the Plan Year in which the distribution of a make-up amount is made prorated for the period from the Retroactive Annuity Starting Date to the date benefit payments actually commence

ARTICLE XI

SUSPENSION OF BENEFITS UPON CERTAIN EMPLOYMENT OR REEMPLOYMENT

11.01 Suspension of Benefits. The application of the suspension of benefit rule with respect to any Participant varies depending on (i) whether and to what extent the Participant continues employment past Normal Retirement Age or (ii) the timing of a Termination of Service and reemployment.

(a) Continuous Employment Past Normal Retirement Age. If a Participant continues to be employed by the Company or a Related Employer after his Normal Retirement Age, a Participant's Vested Accrued Benefit shall be paid or suspended according to the extent of the Participant's employment as follows:

(i) Employment of 40 or More Hours Per Month. No Participant shall receive a Plan benefit for any month beginning on or after the Participant's completes the requirements for a Normal Retirement Benefit if during such month he is credited with 40 or more Hours of Service or receives payment for vacation, holiday, illness, incapacity including disability, layoff, jury duty, military duty, or leave of absence for 40 or more Hours of Service in any calendar month. Department of Labor Regulation Section 2530.203-3, including the notice procedures referred to in Section 10.03, shall be followed for the foregoing period of employment. Any Participant subject to this subsection (i) shall have his Accrued Benefit determined pursuant to Section 7.02.

(ii) Employment of Less Than 40 Hours Per Month. If a Participant who continues to be employed by the Employer after he completes the requirements for a Normal Retirement Benefit receives remuneration for less than 40 Hours of Service in any given calendar month, such Participant is considered retired and is entitled to benefit payments under the Plan. Such Participant shall continue to receive Credited Service or Point Service (as applicable) during the period he is receiving annuity payments, and at the end of each subsequent calendar year after the Participant's Normal Retirement Age, his annuity benefit shall be recalculated to determine if an actuarial adjustment is required.

(b) Termination and Reemployment After Normal Retirement Age. If a former Participant who is entitled to receive a benefit under the Plan has commenced receipt of his Normal Retirement Benefit and is subsequently reemployed by the Employer, he shall continue to be deemed retired under the Plan and his annuity benefit payments shall continue. Such a Participant's period of reemployment after his Normal Retirement Age shall be considered as a period of Credited Service or Point Service (as applicable), and at the end of each subsequent calendar year after the Participant's Normal Retirement Age, his annuity benefit shall be recalculated to determine if an actuarial adjustment is required.

(c) Termination and Reemployment Prior to Normal Retirement Age. Notwithstanding the provisions of subsection (b) above, if any other former Participant has commenced receipt of an Early Retirement Benefit, FAP Disability Benefit or a Deferred Vested Benefit and is thereafter reemployed prior to reaching his Normal Retirement Age, such Early Retirement Benefit, FAP Disability Benefit or Deferred Vested Benefit shall be suspended for the period of the former Participant's subsequent reemployment. If such reemployment continues past Normal Retirement Age, Department of Labor Regulation Section 2530.203-3, including the notice procedures referred to in Section 11.03, shall be followed, and such Participant shall have his Accrued Benefit determined pursuant to Section 6.02 and in accordance with the provisions of Section 11.02 below.

(d) Death After Normal Retirement Age. Upon the death of a Participant who continues his employment beyond his Normal Retirement Age and who is not retired in accordance with the foregoing provisions of this Section, the provisions of Article IX or an effective election of a joint and survivor annuity benefit, and the survivorship annuity benefit to his Spouse, if any, shall commence as of the first day of the month coincident with or next following the Participant's death in the amount which would have been payable had the Participant retired immediately prior to his death.

11.02 Benefits Upon Reemployment. Benefits upon the reemployment of an Employee shall be determined as set forth below.

(a) In General – Application of Next Gen Employee Provisions. Next Gen Employees are not considered Eligible Employees and shall not accrue any additional benefit under the Plan when reemployed by the Employer. While benefit payments (if applicable) to such a Next Gen Employee shall be suspended in accordance with Section 11.01, the automatic AB II Benefit conversion provisions that went into effect January 1, 2008 (as described below) shall not apply.

(b) Reemployments Occurring Prior to the Application of the Next Gen Employee Provisions. Effective January 1, 2008 and prior to the application of the Next Gen benefit structure, any reemployed Eligible Employee shall participate in the AB II Benefit pursuant to Article IV. The benefits payable upon a Participant's subsequent Termination of Service shall be determined as follows:

(i) Reemployment Before Commencing Benefits. If the Participant is reemployed before he has received or begun to receive a benefit under the Plan, his Credited Service and Point Service shall be restored if the Participant satisfies the requirements of Section 2.04(a). The value of the Participant's vested AB I Account or vested AB II Account, as applicable, upon reemployment is equal to the balance, if any, as of his Termination of Service, increased with Interest Credits for the period of absence. Notwithstanding the foregoing, effective January 1, 2008, any undistributed FAP Benefit or AB I Benefit shall be converted to an Opening Balance in accordance with the AB II provisions of Section 4.03(b) and such Participant shall begin to accrue an AB II Benefit upon his reemployment.

(ii) Reemployment After Commencing Annuity Benefits. If the Participant is reemployed after he has begun to receive an annuity benefit under the Plan, his Credited Service and Point Service shall be restored, and his benefit after reemployment shall be determined as follows:

(A) On or after January 1, 2008, and prior to the application of the Next Gen benefit structure if the Participant is a FAP Participant who has had benefits suspended pursuant to Section 11.01(c), the Participant's annuity benefits under to the FAP Benefit shall be converted to an Opening Balance in accordance with the AB II provisions of Section 4.03(b). For purposes of calculating such Participant's Protected Benefit pursuant to Section 4.07(a), upon the Participant's subsequent Benefit Commencement Date, the Protected Benefit shall be reduced by the amount of the annuity benefits received by the Participant. Prior to January 1, 2008, such a Participant's FAP Benefit was re-determined pursuant to Article VI upon the Participant's subsequent Termination of Service as if he then first retired, based on the Participant's Credited Service and Compensation before and after his absence. The Participant shall receive Pay-Based Credits pursuant to Section 4.04, based on the Participant's Point Service before and after the absence and his Compensation after the absence.

(B) On or after January 1, 2008, and prior to the application of the Next Gen benefit structure, if the Participant is an AB I Participant or AB II Participant who has had benefits suspended pursuant to Section 11.01(c), upon reemployment, the Participant's annuity benefits under the AB I or the AB II Benefit shall be converted to an Opening Balance in accordance with the AB II provisions of Section 4.03(b). For purposes of calculating such Participant's Protected Benefit pursuant to Section 4.07(b), if any, upon the Participant's subsequent Benefit Commencement Date, the Protected Benefit shall be reduced by the amount of the annuity benefits received by the Participant. Prior to January 1, 2008, an Opening Balance was calculated pursuant to Section 4.03(b) or 5.03(b), as applicable, based on the Single Life Annuity that was the Actuarial Equivalent of the annuity payment being made by the Plan. The Participant shall receive Pay-Based Credits pursuant to Section 4.04, based on the Participant's Point Service before and after the absence and his Compensation after the absence.

(C) Notwithstanding the foregoing, if a Participant is a FAP Participant, AB I Participant or AB II Participants who has had benefits continue due to reemployment past Normal Retirement Age pursuant to Section 11.01(b), such Participant shall continue to receive any annuity payment commenced prior to reemployment but shall, upon reemployment, participate in the AB II Benefit pursuant to this Section and Article IV and shall begin to accrue an AB II Benefit with a $0 Opening Balance.

(D) The Participant shall be entitled during this period of reemployment (subject to the election procedures of Article X) to revise any prior election affecting the form in which benefits are paid, provided that the amount of any annuity benefit payable after his subsequent Termination of Service shall not be less than the amount payable in that form of payment as of his original Termination of Service.

(iii) Reemployment After Lump Sum Distribution. If the Participant is reemployed after receiving a lump sum distribution of his benefit under the Plan, his Credited Service and Point Service shall not be restored. However, the Plan shall consider all Vesting Service earned under the Plan. A Participant's benefit after reemployment shall be determined as follows:

(A) A FAP Participant shall become an AB II Participant with a $0 Opening Balance and shall receive Pay-Based Credits pursuant to Section 4.04 based on the Participant's Point Service and Compensation after reemployment. Prior to January 1, 2008, if the Participant was a FAP Participant on or after reemployment, his FAP Benefit was based on the Participant's Credited Service after reemployment and his Compensation before and after the absence.

(B) An AB I Participant or an AB II Participant shall resume participation in the Plan as an AB II Participant with a $0 Opening Balance. The Participant shall receive Pay-Based Credits pursuant to 4.04 (or prior to January 1, 2008, if applicable, Section 5.04) based on the Participant's Point Service and Compensation after reemployment.

11.03 Suspension of Benefits Notice. In the case of a Participant whose benefits are to be suspended after his Normal Retirement Age, the Plan Administrator shall notify him of the suspension by providing notice in accordance with and to the extent required by Department of Labor Regulation Section 2530.203-3.

(a) Notice Content and Delivery. Any Participant who is required to receive a notice pursuant to this Section shall be notified (by personal delivery or certified or registered mail) during the first calendar

month in which payments are withheld, that his annuity benefit is suspended. Such notification shall include:

(i) a description of the specific reasons for the suspension of payments;

(ii) a general description of the Plan provisions relating to the suspension;

(iii) a copy of the provisions;

(iv) a statement to the effect that applicable Department of Labor Regulations may be found at Section 2530.203-3 of Title 29 of the Code of Federal Regulations;

(v) the procedure for appealing the suspension, which procedure shall be governed by Sections 15.07 and 15.08; and

(vi) the procedure for filing a benefits resumption notification.

If payments subsequent to the suspension are to be offset by any amount paid prior to the suspension, the notification shall specifically identify the periods of employment for which the amounts to be offset were paid, the amounts subject to offset and the manner in which the Plan intends to offset such amounts.

(b) If the Summary Plan Description ("SPD") for the Plan contains information that is substantially the same as information required pursuant this Section, the notification may refer the Participant to the relevant pages of the SPD. If the notification refers to the SPD, the notification shall also inform the Participant how to obtain a copy of the SPD, or relevant pages thereof, and any request for the referenced information shall be honored within 30 days of the receipt by the Plan Administrator of such request.

(c) A Participant may request, pursuant to the procedure contained in Sections 15.07 and 15.08, a determination whether specific contemplated employment will constitute employment during which payment of a Pension will be suspended pursuant to this Section.

ARTICLE XII

CONTRIBUTIONS

12.01 Employer Contributions. The Employer shall make the contributions required to fund the cost of the benefits provided by this Plan. The Employer intends to make such contributions as are necessary to fund the Plan in accordance with the minimum funding standards of the Code. Contributions by the Employer are conditioned upon their deductibility under the Code for federal income tax purposes. Notwithstanding any provision in the Plan to the contrary, contributions and benefits shall be determined and paid in accordance with Code Section 436 and the provisions set forth in Schedule III which shall apply effective as of the date set forth in such Schedule.

12.02 Determination of Employer Contribution. The Employer, from its records and the reports of the actuary for the Plan, shall determine the amount of any contribution to be made by it to the Trust under the terms of the Plan. In this regard, the Employer may place full reliance upon all reports, opinions, tables, valuations, certificates and computations the actuary for the Plan furnishes the Employer.

12.03 Time of Payment of Employer Contribution. The Employer shall make its contribution to the Trustee within the time prescribed by the Code or applicable Treasury Regulations.

12.04 Return of Employer Contributions. Notwithstanding Section 20.01:

(a) In the case of a contribution made by the Employer by a mistake of fact, such contribution may be returned to the Employer within one year after its payment.

(b) All employer contributions to the Plan are conditioned on the allowance of their deductibility for federal income tax purposes under the Code. If the deduction of a contribution is disallowed by the Internal Revenue Service, to the extent of disallowance, the contribution may be returned to the Employer within one year after the disallowance.

(c) Any amounts returned under this Section shall be disposed of as directed by the Plan Administrator through uniform and nondiscriminatory rules. The Trustee shall not increase the amount of any contribution returnable under this Section for any earnings attributable to the contribution, but the Trustee shall decrease the Employer contribution returnable for any losses attributable to it.

12.05 Application of Forfeitures. The Trustee shall retain in the Trust all amounts representing the nonvested Accrued Benefit of Participants who have terminated employment. The Employer shall not use such benefits to increase the benefit of other Participants but instead shall use such amounts to reduce its contribution for future Plan Years.

12.06 Employee Contributions. The Plan does not permit nor require contributions from Participants.

ARTICLE XIII

LIMITATION ON BENEFITS

13.01 Effective Date. The limitations of this Article shall apply in Limitation Years beginning on or after July 1, 2007, except as otherwise provided herein.

13.02 Annual Benefit. The Annual Benefit otherwise payable to a Participant under the Plan at any time shall not exceed the Maximum Permissible Benefit. If the benefit the Participant would otherwise accrue in a Limitation Year would produce an Annual Benefit in excess of the Maximum Permissible Benefit, the benefit shall be limited (or the rate of accrual reduced) to a benefit that does not exceed the Maximum Permissible Benefit.

13.03 Other Defined Benefit Plans. If the Participant is, or has ever been, a Participant in another qualified defined benefit Plan (without regard to whether the Plan has been terminated) maintained by the Employer or a predecessor Employer, the sum of the Participant's Annual Benefits from all such Plans may not exceed the Maximum Permissible Benefit. Where the Participant's employer-provided benefits under all such defined benefit Plans (determined as of the same age) would exceed the Maximum Permissible Benefit applicable at that age, adjustment shall be made in the last plan in which the Participant actively participated prior to the determination of the Maximum Permissible Benefit.

13.04 Grandfather Provision. The application of the provisions of this Article shall not cause the Maximum Permissible Benefit for any Participant to be less than the Participant's accrued benefit under all the defined benefit plans of the Employer or a predecessor Employer as of the end of the last Limitation Year beginning before July 1, 2007 under provisions of the plans that were both adopted and in effect before April 5, 2007. The preceding sentence applies only if the provisions of such defined benefit Plans that were both adopted and in effect before April 5, 2007 satisfied the applicable requirements of statutory provisions, regulations, and other published guidance relating to Code Section 415 in effect as of the end of the last Limitation Year beginning before July 1, 2007, as described in Treasury Regulation Section 1.415(a)-1(g)(4).

13.05 Coordination with Other Rules. The limitations of this Article shall be determined and applied taking into account the rules in Section 13.07.

13.06 Definitions.

(a) Annual Benefit: A benefit that is payable annually in the form of a straight life annuity. Except as provided below, where a benefit is payable in a form other than a straight life annuity, the benefit shall be adjusted to an actuarially equivalent straight life annuity that begins at the same time as such other form of benefit and is payable on the first day of each month, before applying the limitations of this Article. For a Participant who has or will have distributions commencing at more than one annuity starting date, the Annual Benefit shall be determined as of each such annuity starting date (and shall satisfy the limitations of this Article as of each such date), actuarially adjusting for past and future distributions of benefits commencing at the other annuity starting dates. For this purpose, the determination of whether a new starting date has occurred shall be made without regard to Treasury Regulation Sections 1.401(a)-20, Q&A-10(d), and with regard to Treasury Regulation Sections 1.415(b)-1(b)(1)(iii)(B) and (C).

No actuarial adjustment to the benefit shall be made for (a) survivor benefits payable to a surviving Spouse under a qualified joint and survivor annuity to the extent such benefits would not be payable if the Participant's benefit were paid in another form; (b) benefits that are not directly related to retirement benefits (such as a qualified disability benefit, preretirement incidental death benefits, and

postretirement medical benefits); or (c) the inclusion in the form of benefit of an automatic benefit increase feature, provided the form of benefit is not subject to Code Section 417(e)(3) and would otherwise satisfy the limitations of this Article, and the Plan provides that the amount payable under the form of benefit in any Limitation Year shall not exceed the limits of this Article applicable at the annuity starting date, as increased in subsequent years pursuant to Code Section 415(d). For this purpose, an automatic benefit increase feature is included in a form of benefit if the form of benefit provides for automatic, periodic increases to the benefits paid in that form.

The determination of the Annual Benefit shall take into account social security supplements described in Code Section 411(a)(9) and benefits transferred from another defined benefit Plan, other than transfers of distributable benefits pursuant Treasury Regulation Section 1.411(d)-4, Q&A-3(c), but shall disregard benefits attributable to employee contributions or rollover contributions.

Effective for distributions in Plan years beginning after December 31, 2003, the determination of actuarial equivalence of forms of benefit other than a straight life annuity shall be made in accordance with Section 13.06(a)(i) or Section 13.06(a)(ii).

(i) Benefit Forms Not Subject to Code Section 417(e)(3): The straight life annuity that is actuarially equivalent to the Participant's form of benefit shall be determined under this Section 13.06(a)(i) if the form of the Participant's benefit is either (1) a nondecreasing annuity (other than a straight life annuity) payable for a period of not less than the life of the Participant (or, in the case of a qualified pre-retirement survivor annuity, the life of the surviving Spouse), or (2) an annuity that decreases during the life of the Participant merely because of (a) the death of the survivor annuitant (but only if the reduction is not below 50% of the benefit payable before the death of the survivor annuitant), or (b) the cessation or reduction of Social Security supplements or qualified disability payments (as defined in Code Section 401(a)(11)).

(A) Limitation Years beginning before July 1, 2007. For Limitation Years beginning before July 1, 2007, the actuarially equivalent straight life annuity is equal to the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit computed using whichever of the following produces the greater annual amount: (I) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form; and (II) a 5 percent interest rate assumption and the applicable mortality table defined in the Plan for that annuity starting date.

(B) Limitation Years beginning on or after July 1, 2007. For Limitation Years beginning on or after July 1, 2007, the actuarially equivalent straight life annuity is equal to the greater of (1) the annual amount of the straight life annuity (if any) payable to the Participant under the Plan commencing at the same annuity starting date as the Participant's form of benefit; and (2) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using a 5 percent interest rate assumption and the applicable mortality table defined in the Plan for that annuity starting date.

(ii) Benefit Forms Subject to Code Section 417(e)(3): The straight life annuity that is actuarially equivalent to the Participant's form of benefit shall be determined under this paragraph if the

form of the Participant's benefit is other than a benefit form described in Section 13.06(a)(i). In this case, the actuarially equivalent straight life annuity shall be determined as follows:

(A) Annuity Starting Date in Plan Years Beginning After 2005. If the annuity starting date of the Participant's form of benefit is in a Plan year beginning after 2005, the actuarially equivalent straight life annuity is equal to the greatest of (I) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form; (II) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using a 5.5 percent interest rate assumption and the applicable mortality table defined in the Plan; and (III) the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using the applicable interest rate defined in the Plan and the applicable mortality table defined in the Plan, divided by 1.05.

(B) Annuity Starting Date in Plan Years Beginning in 2004 or 2005. If the annuity starting date of the Participant's form of benefit is in a Plan year beginning in 2004 or 2005, the actuarially equivalent straight life annuity is equal to the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using whichever of the following produces the greater annual amount: (I) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form; and (II) a 5.5 percent interest rate assumption and the applicable mortality table defined in the Plan.

(C) Transitional Rule. If the annuity starting date of the Participant's benefit is on or after the first day of the first Plan year beginning in 2004 and before December 31, 2004, the application of this Section 13.06(a)(ii)(C) shall not cause the amount payable under the Participant's form of benefit to be less than the benefit calculated under the Plan, taking into account the limitations of this Article, except that the actuarially equivalent straight life annuity is equal to the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the Participant's form of benefit, computed using whichever of the following produces the greatest annual amount:

1. the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan for adjusting benefits in the same form;

2. the applicable interest rate defined in the Plan and the applicable mortality table defined in the Plan; and

3. the applicable interest rate defined in the Plan (as in effect on the last day of the last Plan year beginning before January 1, 2004, under provisions of the Plan then adopted and in effect) and the applicable mortality table defined in the Plan.

(b) Compensation: Compensation is defined as wages, within the meaning of Code Section 3401(a), and all other payments of compensation to an employee by the Employer (in the course of the Employer's

trade or business) for which the Employer is required to furnish the employee a written statement under Code Sections 6041(d), 6051(a)(3), and 6052 (commonly referred to as Form W-2 wages). Compensation shall be determined without regard to any rules under Code Section 3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Code Section 3401(a)(2)).

For any self-employed individual, Compensation shall mean earned income.

Except as provided herein, for Limitation Years beginning after December 31, 1991, compensation for a Limitation Year is the compensation actually paid or made available during such Limitation Year.

For Limitation Years beginning on or after July 1, 2007, compensation for a Limitation Year shall also include compensation paid by the later of 2-1/2 months after an employee's severance from employment with the Employer maintaining the Plan or the end of the Limitation Year that includes the date of the employee's severance from employment with the Employer maintaining the Plan, if:

(i) the payment is regular compensation for services during the employee's regular working hours, or compensation for services outside the employee's regular working hours (such as overtime or shift differential), commissions, bonuses, or other similar payments, and, absent a severance from employment, the payments would have been paid to the employee while the employee continued in employment with the Employer;

(ii) the payment is for unused accrued bona fide sick, vacation or other leave that the employee would have been able to use if employment had continued; or

(iii) the payment is received by the employee pursuant to a nonqualified unfunded deferred compensation Plan and would have been paid at the same time if employment had continued, but only to the extent includible in gross income.

Any payments not described above shall not be considered compensation if paid after severance from employment, even if they are paid by the later of 2-1/2 months after the date of severance from employment or the end of the Limitation Year that includes the date of severance from employment.

Back pay, within the meaning of Treasury Regulation Section 1.415(c)-2(g)(8), shall be treated as compensation for the Limitation Year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

For Limitation Years beginning after December 31, 1997, compensation paid or made available during such Limitation Year shall include amounts that would otherwise be included in Compensation but for an election under Code Sections 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b).

For Limitation Years beginning after December 31, 2000, Compensation shall also include any elective amounts that are not includible in the gross income of the employee by reason of Code Section 132(f)(4).

Compensation shall not include amounts paid as compensation to a nonresident alien, as defined in Code Section 7701(b)(1)(B), who is not a Participant in the Plan to the extent the compensation is excludable from gross income and is not effectively connected with the conduct of a trade or business within the United States.

(c) Defined Benefit Compensation Limitation: 100 percent of a Participant's High Three-Year Average Compensation, payable in the form of a straight life annuity.

In the case of a Participant who is rehired after a severance from employment, the Defined Benefit Compensation Limitation is the greater of 100 percent of the Participant's High Three-Year Average Compensation, as determined prior to the severance from employment, as adjusted pursuant to the preceding paragraph, if applicable; or 100 percent of the Participant's High Three-Year Average Compensation, as determined after the severance from employment under Section 13.06(g).

(d) Defined Benefit Dollar Limitation: Effective for Limitation Years ending after December 31, 2013, the Defined Benefit Dollar Limitation is $210,000, automatically adjusted under Code Section 415(d), effective January 1 of each year, as published in the Internal Revenue Bulletin, and payable in the form of a straight life annuity. The new limitation shall apply to Limitation Years ending with or within the calendar year of the date of the adjustment, but a Participant's benefits shall not reflect the adjusted limit prior to January 1 of that calendar year. In the case of a Participant who has had a severance from employment with the Employer, the Defined Benefit Dollar Limitation applicable to the Participant in any Limitation Year beginning after the date of severance shall be automatically adjusted under Code Section 415(d).

(e) Employer: For purposes of this Article, Employer shall mean the Employer that adopts this Plan, and all members of a controlled group of corporations, as defined in Code Section 414(b) (as modified by Section 415(h), all commonly controlled trades or businesses (as defined in Code Section 414(c), as modified, except in the case of a brother-sister group of trades or businesses under common control, by Code Section 415(h)), or affiliated service groups (as defined in Code Section 414(m)) of which the adopting Employer is a part, and any other entity required to be aggregated with the Employer pursuant to Code Section 414(o).

(f) Formerly Affiliated Plan of the Employer: A plan that, immediately prior to the cessation of affiliation, was actually maintained by the Employer and, immediately after the cessation of affiliation, is not actually maintained by the Employer. For this purpose, cessation of affiliation means the event that causes an entity to no longer be considered the Employer, such as the sale of a member controlled group of corporations, as defined in Code Section 414(b), as modified by Code Section 415(h), to an unrelated corporation, or that causes a plan to not actually be maintained by the Employer, such as transfer of plan sponsorship outside a controlled group.

(g) High Three-Year Average Compensation: The average compensation for the three consecutive years of service (or, if the Participant has less than three consecutive years of service, the Participant's longest consecutive period of service, including fractions of years, but not less than one year) with the Employer that produces the highest average. A year of service with the Employer is the calendar year. In the case of a Participant who is rehired by the Employer after a severance from employment, the Participant's high three-year average compensation shall be calculated by excluding all years for which the Participant performs no services for and receives no compensation from the Employer (the break period) and by treating the years immediately preceding and following the break period as consecutive. A Participant's compensation for a year of service shall not include compensation in excess of the limitation under Code Section 401(a)(17) that is in effect for the calendar year in which such year of service begins.

(h) Limitation Year: A Plan Year.

(i) Maximum Permissible Benefit: The lesser of the Defined Benefit Dollar Limitation or the Defined Benefit Compensation Limitation (both adjusted where required, as provided below).

(i) Adjustment for Less Than 10 Years of Participation or Service: If the Participant has less than 10 years of participation in the Plan, the Defined Benefit Dollar Limitation shall be multiplied by a fraction -- (i) the numerator of which is the number of Years (or part thereof, but not less than one year) of Participation in the Plan, and (ii) the denominator of which is 10. In the case of a Participant who has less than ten Years of Service with the Employer, the Defined Benefit Compensation Limitation shall be multiplied by a fraction -- (i) the numerator of which is the number of Years (or part thereof, but not less than one year) of Service with the Employer, and (ii) the denominator of which is 10.

(ii) Adjustment of Defined Benefit Dollar Limitation for Benefit Commencement Before Age 62 or after Age 65: Effective for benefits commencing in Limitation Years ending after December 31, 2001, the Defined Benefit Dollar Limitation shall be adjusted if the annuity starting date of the Participant's benefit is before age 62 or after age 65. If the annuity starting date is before age 62, the Defined Benefit Dollar Limitation shall be adjusted under Section 13.06(i)(ii)(A), as modified by Section 13.06(i)(ii)(C). If the annuity starting date is after age 65, the Defined Benefit Dollar Limitation shall be adjusted under Section 13.06(i)(ii)(B), as modified by Section 13.06(i)(ii)(C).

(A) Adjustment of Defined Benefit Dollar Limitation for Benefit Commencement Before Age 62:

1. Limitation Years Beginning Before July 1, 2007. If the annuity starting date for the Participant's benefit is prior to age 62 and occurs in a Limitation Year beginning before July 1, 2007, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) with actuarial equivalence computed using whichever of the following produces the smaller annual amount: (1) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan; or (2) a 5-percent interest rate assumption and the applicable mortality table as defined in the Plan.

2. Limitation Years Beginning on or After July 1, 2007.

a. Plan Does Not Have Immediately Commencing Straight Life Annuity Payable at Both Age 62 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is prior to age 62 and occurs in a Limitation Year beginning on or after July 1, 2007, and the Plan does not have an immediately commencing straight life annuity payable at both age 62 and the age of benefit commencement, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) with actuarial equivalence computed using a 5 percent interest rate assumption and the applicable mortality table for the annuity starting date as defined in the Plan (and expressing the Participant's age based on completed calendar months as of the annuity starting date).

b. Plan Has Immediately Commencing Straight Life Annuity Payable at Both Age 62 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is prior to age 62 and occurs in a Limitation Year beginning on or after July 1, 2007, and the Plan has an immediately commencing straight life annuity payable at both age 62 and the age of benefit commencement, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the lesser of the limitation determined under Section 13.06(i)(ii)(A)(2)(a) and the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i)) for years of participation less than 10, if required) multiplied by the ratio of the annual amount of the immediately commencing straight life annuity under the Plan at the Participant's annuity starting date to the annual amount of the immediately commencing straight life annuity under the Plan at age 62, both determined without applying the limitations of this Article.

(B) Adjustment of Defined Benefit Dollar Limitation for Benefit Commencement After Age 65:

1. Limitation Years Beginning Before July 1, 2007. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a Limitation Year beginning before July 1, 2007, the Defined Benefit Dollar Limitation for the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) with actuarial equivalence computed using whichever of the following produces the smaller annual amount: (1) the interest rate specified in the Plan and the mortality table (or other tabular factor) specified in the Plan; or (2) a 5-percent interest rate assumption and the applicable mortality table as defined in the Plan.

2. Limitation Years Beginning Before July 1, 2007.

a. Plan Does Not Have Immediately Commencing Straight Life Annuity Payable at Both Age 65 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a Limitation Year beginning on or after July 1, 2007, and the Plan does not have an immediately commencing straight life annuity payable at both age 65 and the age of benefit commencement, the Defined Benefit Dollar Limitation at the Participant's annuity starting date is the annual amount of a benefit payable in the form of a straight life annuity commencing at the Participant's annuity starting date that is the actuarial equivalent of the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required), with actuarial equivalence computed using a 5 percent interest rate assumption and the applicable mortality table for that annuity starting date as defined in the Plan (and expressing the Participant's age based on completed calendar months as of the annuity starting date).

b. Plan Has Immediately Commencing Straight Life Annuity Payable at Both Age 65 and the Age of Benefit Commencement. If the annuity starting date for the Participant's benefit is after age 65 and occurs in a Limitation Year

beginning on or after July 1, 2007, and the Plan has an immediately commencing straight life annuity payable at both age 65 and the age of benefit commencement, the Defined Benefit Dollar Limitation at the Participant's annuity starting date is the lesser of the limitation determined under Section 13.06(i)(ii)(B)(2)(a) and the Defined Benefit Dollar Limitation (adjusted under Section 13.06(i)(i) for years of participation less than 10, if required) multiplied by the ratio of the annual amount of the adjusted immediately commencing straight life annuity under the Plan at the Participant's annuity starting date to the annual amount of the adjusted immediately commencing straight life annuity under the Plan at age 65, both determined without applying the limitations of this Article. For this purpose, the adjusted immediately commencing straight life annuity under the Plan at the Participant's annuity starting date is the annual amount of such annuity payable to the Participant, computed disregarding the Participant's accruals after age 65 but including actuarial adjustments even if those actuarial adjustments are used to offset accruals; and the adjusted immediately commencing straight life annuity under the Plan at age 65 is the annual amount of such annuity that would be payable under the Plan to a hypothetical Participant who is age 65 and has the same accrued benefit as the Participant.

(C) Notwithstanding the other requirements of this Section 13.06(i)(ii), no adjustment shall be made to the Defined Benefit Dollar Limitation to reflect the probability of a Participant's death between the annuity starting date and age 62, or between age 65 and the annuity starting date, as applicable, if benefits are not forfeited upon the death of the Participant prior to the annuity starting date. To the extent benefits are forfeited upon death before the annuity starting date, such an adjustment shall be made. For this purpose, no forfeiture shall be treated as occurring upon the Participant's death if the Plan does not charge Participants for providing a qualified preretirement survivor annuity, as defined in Code Section 417(c), upon the Participant's death.

(j) Minimum benefit permitted: Notwithstanding anything else in this Section to the contrary, the benefit otherwise accrued or payable to a Participant under this Plan shall be deemed not to exceed the Maximum Permissible Benefit if:

(i) the retirement benefits payable for a Limitation Year under any form of benefit with respect to such Participant under this Plan and under all other defined benefit Plans (without regard to whether a Plan has been terminated) ever maintained by the Employer do not exceed $10,000 multiplied by a fraction – (I) the numerator of which is the Participant's number of Years (or part thereof, but not less than one year) of Service (not to exceed 10) with the Employer, and (II) the denominator of which is 10; and

(ii) the Employer (or a predecessor Employer) has not at any time maintained a defined contribution plan in which the Participant participated (for this purpose, mandatory employee contributions under a defined benefit plan, individual medical accounts under Code Section 401(h), and accounts for postretirement medical benefits established under Code Section 419A(d)(1) are not considered a separate defined contribution plan).

(k) Predecessor Employer: If the Employer maintains a plan that provides a benefit which the Participant accrued while performing services for a former Employer, the former Employer is a predecessor Employer with respect to the Participant in the Plan. A former entity that antedates the Employer is

also a predecessor Employer with respect to a Participant if, under the facts and circumstances, the Employer constitutes a continuation of all or a portion of the trade or business of the former entity.

(l) Severance from Employment: An Employee has a severance from employment when the Employee ceases to be an employee of the Employer maintaining the Plan. An Employee does not have a severance from employment if, in connection with a change of employment, the employee's new Employer maintains the Plan with respect to the employee.

(m) Year of Participation: The Participant shall be credited with a Year of Participation (computed to fractional parts of a year) for each accrual computation period for which the following conditions are met: (1) the Participant is credited with at least the number of hours of service (or period of service if the elapsed time method is used) for benefit accrual purposes, required under the terms of the Plan in order to accrue a benefit for the accrual computation period, and (2) the Participant is included as a Participant under the eligibility provisions of the Plan for at least one day of the accrual computation period. If these two conditions are met, the portion of a year of participation credited to the Participant shall equal the amount of benefit accrual service credited to the Participant for such accrual computation period. A Participant who is permanently and totally disabled within the meaning of Code Section 415(c)(3)(C)(i) for an accrual computation period shall receive a Year of Participation with respect to that period. In addition, for a Participant to receive a Year of Participation (or part thereof) for an accrual computation period, the Plan must be established no later that the last day of such accrual computation period. In no event shall more than one Year of Participation be credited for any 12-month period.

(n) Year of Service: For purposes of Section 13.06(g), the Participant shall be credited with a Year of Service (computed to fractional parts of a year) for each accrual computation period for which the Participant is credited with at least the number of hours of service (or period of service if the elapsed time method is used) for benefit accrual purposes, required under the terms of the Plan in order to accrue a benefit for the accrual computation period, taking into account only service with the Employer or a predecessor Employer.

13.07 Other Rules.

(a) Benefits Under Terminated Plans. If a defined benefit Plan maintained by the Employer has terminated with sufficient assets for the payment of benefit liabilities of all Plan Participants and a Participant in the Plan has not yet commenced benefits under the Plan, the benefits provided pursuant to the annuities purchased to provide the Participant's benefits under the terminated Plan at each possible annuity starting date shall be taken into account in applying the limitations of this Article. If there are not sufficient assets for the payment of all Participants' benefit liabilities, the benefits taken into account shall be the benefits that are actually provided to the Participant under the terminated Plan.

(b) Benefits Transferred From the Plan. If a Participant's benefits under a defined benefit Plan maintained by the Employer are transferred to another defined benefit Plan maintained by the Employer and the transfer is not a transfer of distributable benefits pursuant to Treasury Regulation Section 1.411(d)-4, Q&A-3(c), the transferred benefits are not treated as being provided under the transferor Plan (but are taken into account as benefits provided under the transferee Plan). If a Participant's benefits under a defined benefit Plan maintained by the Employer are transferred to another defined benefit Plan that is not maintained by the Employer and the transfer is not a transfer of distributable benefits pursuant Treasury Regulation Section 1.411(d)-4, Q&A-3(c), the transferred benefits are treated by the Employer's Plan as if such benefits were provided under annuities purchased to provide benefits under a Plan maintained by the Employer that terminated immediately prior to the transfer with sufficient

assets to pay all Participants' benefit liabilities under the Plan. If a Participant's benefits under a defined benefit Plan maintained by the Employer are transferred to another defined benefit Plan in a transfer of distributable benefits pursuant Treasury Regulation Section 1.411(d)-4, Q&A-3(c), the amount transferred is treated as a benefit paid from the transferor Plan.

(c) Formerly Affiliated Plans of the Employer. A formerly affiliated plan of an Employer shall be treated as a plan maintained by the Employer, but the formerly affiliated plan shall be treated as if it had terminated immediately prior to the cessation of affiliation with sufficient assets to pay Participants' benefit liabilities under the Plan and had purchased annuities to provide benefits.

(d) Plans of a Predecessor Employer. If the Employer maintains a defined benefit Plan that provides benefits accrued by a Participant while performing services for a predecessor Employer, the Participant's benefits under a Plan maintained by the predecessor Employer shall be treated as provided under a Plan maintained by the Employer. However, for this purpose, the Plan of the predecessor Employer shall be treated as if it had terminated immediately prior to the event giving rise to the predecessor Employer relationship with sufficient assets to pay Participants' benefit liabilities under the Plan, and had purchased annuities to provide benefits; the Employer and the predecessor Employer shall be treated as if they were a single Employer immediately prior to such event and as unrelated Employers immediately after the event; and if the event giving rise to the predecessor relationship is a benefit transfer, the transferred benefits shall be excluded in determining the benefits provide under the Plan of the predecessor Employer.

(e) Special Rules. The limitations of this Article shall be determined and applied taking into account the rules in Treasury Regulation Sections 1.415(f)-1(d), (e), and (h).

(f) Aggregation with Multiemployer Plans.

(i) If the Employer maintains a multiemployer Plan, as defined in Code 414(f), and the multiemployer plan so provides, only the benefits under the multiemployer plan that are provided by the Employer shall be treated as benefits provided under a plan maintained by the Employer for purposes of this Article.

(ii) Effective for Limitation Years ending after December 31, 2001, a multiemployer plan shall be disregarded for purposes of applying the compensation limitation of Sections 13.06(c) and 13.06(i)(i) to a plan which is not a multiemployer plan.

ARTICLE XIV

EMPLOYER ADMINISTRATIVE PROVISIONS

14.01 Information To Plan Administrator. The Employer shall supply current information to the Plan Administrator as to the name, date of birth, date of employment, annual compensation, leaves of absence, Years of Service and date of termination of employment of each Employee who is, or who will be eligible to become, a Participant under the Plan, together with any other information which the Plan Administrator considers necessary. The Employer's records as to the current information the Employer furnishes to the Plan Administrator are conclusive as to all persons.

14.02 No Liability. The Employer assumes no obligation or responsibility to any of its Employees, Participants or Beneficiaries for any act of, or failure to act, on the part of the Committee or the Trustee.

14.03 Indemnity Of Committee. The Employer indemnifies and saves harmless the members of the Committee, and each of them, from and against any and all loss (including reasonable attorney's fees and costs of defense) resulting from liability to which the Committee, or the members of the Committee, may be subjected by reason of any act or conduct (except willful misconduct or gross negligence) in their official capacities in the administration of this Plan, the Trust, or both, including all expenses reasonably incurred in their defense, in case the Employer fails to provide such defense. The indemnification provisions of this Section shall not relieve any Committee member from any liability he may have under ERISA for breach of a fiduciary duty to the extent such indemnification is prohibited by ERISA. Furthermore the Committee members and the Employer may execute an agreement further delineating the indemnification agreement of this Section, provided the agreement must be consistent with and shall not violate ERISA.

ARTICLE XV

PARTICIPANT ADMINISTRATIVE PROVISIONS

15.01 Personal Data To Plan Administrator. Each Participant and each Beneficiary of a deceased Participant must furnish to the Plan Administrator such evidence, data or information as the Plan Administrator considers necessary or desirable for the purpose of administering the Plan. The provisions of this Plan are effective for the benefit of each Participant upon the condition precedent that each Participant will furnish promptly full, true and complete evidence, data and information when requested by the Plan Administrator, provided the Plan Administrator shall advise each Participant of the effect of his failure to comply with its request.

15.02 Address For Notification. Each Participant and each Beneficiary of a deceased Participant shall file with the Plan Administrator from time to time, in writing, his post office address and any change of post office address. Any communication, statement or notice addressed to a Participant, or Beneficiary, at his last post office address filed with the Plan Administrator, or as shown on the records of the Employer, shall bind the Participant, or Beneficiary, for all purposes of this Plan.

15.03 Notice Of Change In Terms. The Employer, within the time prescribed by ERISA and the applicable regulations, shall furnish all Participants and Beneficiaries a summary description of any material amendment to the Plan or notice of discontinuance of the Plan and all other information required by ERISA to be furnished without charge.

15.04 Assignment Or Alienation. Subject to Code Section 414(p) relating to qualified domestic relations orders, neither a Participant nor a Beneficiary shall anticipate, assign or alienate (either at law or in equity) any benefit provided under the Plan, and the Trustee shall not recognize any such anticipation, assignment or alienation. Furthermore, a benefit under the Plan is not subject to attachment, garnishment, levy, execution, or other legal or equitable process, including the claims of any trustee in bankruptcy or other representative of the Participant or Beneficiary in such action.

15.05 Litigation Against The Plan. If any legal action which is filed against the Trustee, the Plan Administrator, the Company as Plan sponsor, or the Committee, or against any member or members of the Committee, by or on behalf of any Participant or Beneficiary, results adversely to the Participant or to the Beneficiary, the Trustee shall reimburse itself, the Employer, the Company, or the Committee, or any member or members of the Committee, all costs and fees expended by it or them by surcharging all costs and fees against the sums payable under the Plan to the Participant or to the Beneficiary, but only to the extent a court of competent jurisdiction specifically authorizes and directs any such surcharges and only to the extent Code Section 401(a)(13) does not prohibit any such surcharges.

15.06 Information Available. Any Participant in the Plan or any Beneficiary may, during reasonable business hours, examine copies of the Plan description, latest annual report, any bargaining agreement, this Plan and Trust, and any contract or other instrument under which the Plan was established or is operated. The Employer shall maintain all of the items listed in this Section in its offices, or in such other place or places as it may designate from time to time in order to comply with the regulations issued under ERISA. Upon the written request of a Participant or Beneficiary, the Employer shall furnish him with a copy of any item listed in this Section. The Employer may make a reasonable charge to the requesting person for the copy so furnished.

15.07 Presenting Claims For Benefits. Any Participant or any other person claiming under a deceased Participant, such as a surviving Spouse or Beneficiary, may submit written application to the Plan Administrator for the payment of any benefit asserted to be due him under the Plan. Such application shall set forth the nature of the claim and such other information as the Plan Administrator may reasonably request. Promptly upon the receipt

of any application required by this Section, the Plan Administrator shall determine whether or not the Participant, Spouse, or Beneficiary involved is entitled to a benefit hereunder and, if so, the amount thereof and shall notify the claimant of its findings.

If a claim is wholly or partially denied, the Plan Administrator shall so notify the claimant within 90 days after receipt of the claim by the Plan Administrator, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the end of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render its final decision. Notice of the Plan Administrator's decision to deny a claim in whole or in part shall be set forth in a manner calculated to be understood by the claimant and shall contain the following:

(a) the specific reason or reasons for the denial;

(b) specific reference to the pertinent Plan provisions on which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(d) an explanation of the claims review procedure set forth in Section 15.08 hereof.

The Employer's notice of denial of benefits shall identify the name and address of the Committee member to whom the claimant may forward his appeal. If notice of denial is not furnished, and if the claim is not granted within the period of time set forth above, the claim shall be deemed denied for purposes of proceeding to the review stage described in Section 15.08.

15.08 Claims Review Procedure. If an application filed under Section 15.07 above shall result in a denial by the Plan Administrator of the benefit applied for, either in whole or in part, such applicant shall have the right, to be exercised by written application filed with the Committee within 60 days after receipt of notice of the denial of his application or, if no such notice has been given, within 60 days after the application is deemed denied under Section 15.07, to request the review of his application and of his entitlement to the benefit applied for. Such request for review may contain such additional information and comments as the applicant may wish to present. Within 60 days after receipt of any such request for review, the Committee shall reconsider the application for the benefit in light of such additional information and comments as the applicant may have presented, and if the applicant shall have so requested, shall afford the applicant or his designated representative a hearing before the Committee. The Committee shall also permit the applicant or his designated representative to review pertinent documents in its possession, including copies of the Plan document and information provided by the Employer relating to the applicant's entitlement to such benefit.

The Committee shall make a final determination with respect to the applicant's application for review as soon as practicable, and in any event not later than 60 days after receipt of the aforesaid request for review, except that under special circumstances, such as the necessity for holding a hearing, such 60-day period may be extended to the extent necessary, but in no event beyond the expiration of 120 days after receipt by the Committee of such request for review. If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the applicant prior to the commencement of the extension. Notwithstanding the foregoing, if the Committee's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Committee's final determination with respect to the applicant's application for review may be made within the period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii) in lieu of the 60-day period (120-day period if extended due to special circumstances) described above.

Notice of such final determination of the Committee shall be furnished to the applicant in writing, in a manner calculated to be understood by him, and shall set forth the specific reasons for the decision and specific references to the pertinent provisions of the Plan upon which the decision is based. If the decision on review is not furnished within the time period set forth above, the claim shall be deemed denied on review.

If such final determination is favorable to the applicant, it shall be binding and conclusive. If such final determination is adverse to such applicant, it shall be binding and conclusive unless the applicant notifies the Committee within 90 days after the mailing or delivery to him by the Committee of its determination that he intends to institute legal proceedings challenging the determination of the Committee, and actually institutes such legal proceeding within 180 days after such mailing or delivery.

15.09 Disputed Benefits. If any dispute shall arise between a Participant, or other person claiming under a Participant, and the Committee after the review of a claim for benefits, or in the event any dispute shall develop as to the person to whom the payment of any benefit under the Plan shall be made, the Trustee may withhold the payment of all or any part of the benefits payable hereunder to the Participant, or other person claiming under the Participant, until such dispute has been resolved by a court of competent jurisdiction or settled by the parties involved.

ARTICLE XVI

ADMINISTRATION

16.01 Allocation Of Responsibility Among Fiduciaries For Plan And Trust Administration. The fiduciaries shall have only those powers, duties, responsibilities and obligations as are specifically given to them under this Plan and the Trust. The Employers shall have the sole responsibility for making the contributions provided for under Article XII. The Committee shall have the sole authority to appoint and remove the Trustee and to amend or terminate, in whole or in part, the Plan or the Trust. The Committee shall have the final responsibility for the administration of the Plan, which responsibility is specifically described in this Plan and the Trust. The Committee shall be the "plan administrator" and the "named fiduciary" within the meaning of Title I of ERISA. In addition, the Committee shall have the specific delegated powers and duties described in the further provisions of this Article and such further powers and duties as specified in the Committee charter. The Trustee shall have the sole responsibility for the administration of the Trust and the management of the assets held under the Trust, all as specifically provided in the Trust.

Each fiduciary warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of this Plan and Trust, authorizing or providing for such direction, information, or action. Furthermore, each fiduciary may rely upon any such direction, information, or action of another fiduciary as being proper under this Plan and the Trust, and is not required under this Plan or the Trust to inquire into the propriety of any such direction, information, or action. It is intended under this Plan and the Trust that each fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and the Trust and shall not be responsible for any act or failure to act of another fiduciary. No fiduciary guarantees the Trust Fund in any manner against investment loss or depreciation in asset value.

16.02 Appointment Of Committee. The NiSource Benefits Committee (the "Committee") has administrative and investment responsibilities with respect to the Plan. In accordance with the Committee charter, the Chief Executive Officer of NiSource (the "CEO") has the authority to appoint and remove members of the Committee. All usual and reasonable expenses of the Committee may be paid in whole or in part by NiSource, and any expenses not paid by NiSource shall be paid by the Trustee out of the principal or income of the Trust Fund. Any members of the Committee who are Employees shall not receive compensation with respect to their services for the Committee.

16.03 Committee Procedures. The Committee may act at a meeting or in writing without a meeting, pursuant to the applicable Committee charter. The Committee may adopt such bylaws and regulations as it deems desirable for the conduct of its affairs. All decisions of the Committee shall be made by the vote of the majority, including actions in writing taken without a meeting. By appropriate action, the Committee may authorize one or more of its members to execute documents on its behalf, and the Trustee, upon written notification of such authorization, shall accept and rely upon such documents until notified in writing that such authorization has been revoked by the Committee.

16.04 Other Committee Powers And Duties. The Committee shall have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the discretionary authority to perform the following powers and duties:

(a) To construe and enforce the terms of the Plan and the rules and regulations it adopts, including the discretionary authority to interpret the Plan documents and documents related to the Plan's operation (including, but not limited to, issues of fact and questions of eligibility, benefits, status and rights of participants);

(b) To adopt rules of procedure and regulations necessary for the proper and efficient administration of the Plan, provided the rules are not inconsistent with the terms of the Plan and the Trust;

(c) To authorize and approve amendments to and restatements of the Plan;

(d) To direct the Trustee with respect to the crediting and distribution of the Trust;

(e) To review and render decisions respecting a claim for (or denial of a claim for) a benefit under the Plan, including judgment of the standard of proof required in any claim, subject to the requirements of applicable law and the Plan;

(f) To furnish the Employer with information which the Employer may require for tax or other purposes;

(g) To cause to be made all reports or other filing necessary to meet the reporting, disclosure and other filing requirements of the Code, ERISA and other applicable statutes, regulations and other authorities issued thereunder that are the responsibility of the Plan Administrator;

(h) To enlist or engage the services of employees of the Employer and other agents to assist it with the performance of any of its duties, as the Committee determines advisable;

(i) To engage the services of one or more "Investment Managers" (as defined in ERISA Section 3(38)), each of whom shall have full power and authority to manage, acquire or dispose (or direct the Trustee with respect to acquisition or disposition) of any Plan asset under its control;

(j) To establish and maintain a funding standard account and to make credits and charges to the account to the extent required by and in accordance with the provisions of the Code;

(k) To authorize any one of its members, or its secretary, to sign on its behalf any notices, directions, applications, certificates, consents, approvals, waivers, letters or other documents, such authority being evidenced by an instrument signed by all members and filed with the Trustee; and

(l) To make plan corrections permitted by the Employee Plans Compliance Resolution System ("EPCRS") issued by the Internal Revenue Service ("IRS"), as in effect from time to time, as follows: (i) to voluntarily correct any Plan qualification failure, including, but not limited to, failures involving Plan operation, impermissible discrimination in favor of Highly Compensated Employees, the specific terms of the Plan document, or demographic failures; (ii) implement any correction methodology permitted under EPCRS; and (iii) negotiate the terms of a compliance statement or a closing agreement proposed by the IRS with respect to correction of a Plan qualification failure.

16.05 Records And Reports. The Committee (or its delegate) shall exercise such authority and responsibility as it deems appropriate in order to comply with ERISA and regulations issued thereunder relating to records of Participants' Service, Accrued Benefit and the percentage of such Accrued Benefit that is Vested under the Plan; notifications to Participants; annual registration with the Internal Revenue Service; and annual reports to the Department of Labor.

16.06 Rules And Decisions. The Committee may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Committee shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Committee shall be entitled to rely upon information furnished by a Participant or Beneficiary, the Employer, the legal counsel of the Company, or the Trustee. Any determination by the Committee shall presumptively be conclusive and binding on all persons. The regularly kept records of the Company shall be conclusive and binding upon all persons with

respect to an Employee's date and length of employment, time and amount of Compensation and the manner of payment thereof, type and length of any absence from work, and all other matters contained therein relating to Employees.

16.07 Application And Forms For Benefits. The Committee may require a Participant or Beneficiary to complete and file with the Committee an application for a benefit and all other forms approved by the Committee, and to furnish all pertinent information requested by the Committee. The Committee may rely upon all such information so furnished it, including the Participant's or Beneficiary's current mailing address.

16.08 Authorization Of Benefit Payments. The Committee shall issue directions to the Trustee concerning all benefits that are to be paid from the Trust Fund pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with this Plan.

16.09 Funding Policy. The Committee shall review, not less often than annually, all pertinent Employee information and Plan data in order to establish the funding policy of the Plan and to determine the appropriate methods of carrying out the Plan's objectives. The Committee shall communicate periodically, as it deems appropriate, to the Trustee and to any Plan Investment Manager, the Plan's short-term and long-term financial needs so that investment policy can be coordinated with Plan financial requirements.

16.10 Unclaimed Accrued Benefit – Procedure. The Plan does not require the Employer, the Trustee or the Committee to search for, or ascertain the whereabouts of, any Participant or Beneficiary. It shall be the sole duty and responsibility of a Participant or Beneficiary to keep the Employer apprised of his whereabouts and of his most current mailing address. If any benefit to be paid under the Plan is unclaimed, within such time period as the Employer shall prescribe, it shall be forfeited and applied to reduce future costs. However, if the payee later files a claim for that benefit before his benefit has been escheated under applicable law and if that claim is approved, the forfeited benefit will be restored. If a forfeited benefit is restored, the Committee shall direct the Trustee to distribute the Participant's or Beneficiary's restored Accrued Benefit in accordance with Article VII as if the Participant's employment terminated in the Plan Year in which the Committee restores the forfeited Accrued Benefit.

16.11 Fiduciary Duties. In performing their duties, all fiduciaries with respect to the Plan shall act solely in the interest of the Participants and their Beneficiaries, and:

(a) For the exclusive purpose of providing benefits to the Participants and their Beneficiaries;

(b) With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims;

(c) To the extent a fiduciary possesses and exercises investment responsibilities, by diversifying the investments of the Trust so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(d) In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with the provisions of Title I of ERISA.

16.12 Allocation Or Delegation Of Duties And Responsibilities. In furtherance of their duties and responsibilities under the Plan, the Committee may, subject to the requirements of Section 16.11:

(a) Employ agents to carry out nonfiduciary responsibilities;

(b) Employ agents to carry out fiduciary responsibilities (other than trustee responsibilities as defined in ERISA Section 405(c)(3));

(c) Consult with counsel, who may be of counsel to the Employer or the Company; and

(d) Provide for the allocation of fiduciary responsibilities (other than trustee responsibilities as defined in ERISA Section 405(c)(3)) among the members of the Committee.

16.13 Procedure For The Allocation Or Delegation Of Fiduciary Duties.

Any action described in subsections (b) or (d) of Section 16.12 may be taken by the Committee only in accordance with the following procedure:

(a) Such action shall be taken by a majority of the Committee in a resolution approved by a majority of such Committee;

(b) The vote cast by each member of the Committee for or against the adoption of such resolution shall be recorded and made a part of the written record of the Committee's proceedings; and

(c) Any delegation of fiduciary responsibilities or any allocation of fiduciary responsibilities among members of the Committee may be modified or rescinded by the Committee according to the procedure set forth in subsections (a) and (b) of this Section 16.13.

16.14 Individual Statement. As determined in its discretion, the Plan Administrator shall, as soon as practicable and within the time prescribed by ERISA and the regulations under ERISA, deliver to such Participant (or Beneficiary of a deceased Participant) a statement reflecting the condition of his Accrued Benefit as of that date and such other information ERISA requires be furnished the Participant or Beneficiary upon request. No Participant, except a member of the Committee or its designated representative, shall have the right to inspect the records reflecting the Accrued Benefit of any other Participant.

16.15 Recovery of Overpaid Benefits. If a payment of benefits to a Participant, Beneficiary or other individual entitled to payment under the Plan (such as an alternate payee pursuant to Section 9.09) (collectively, the "Recipient") exceeds the amount provided for under the terms of the Plan, either by mistake or for any other reason, the Plan Administrator shall have the authority to seek reimbursement of such overpaid benefits from the Recipient (plus interest calculated in accordance with guidance set forth by the Internal Revenue Service). If a Recipient is receiving benefit payments at the time an overpayment of prior benefits is discovered, the Plan Administrator shall have the authority to reduce such Recipient's benefit payments going forward in an amount as necessary in the Plan Administrator's discretion to recover the overpaid benefits.

ARTICLE XVII

TRUST FUND

17.01 Establishment Of Trust. On behalf of the Plan, an agreement has been executed (the "Trust Agreement") to establish a trust to hold the assets of the Plan (the "Trust") and to appoint one or more persons or parties who shall serve as the Trustee. The Trustee so selected shall serve as the Trustee until otherwise replaced by the Committee or said Trust Agreement is terminated. The Committee may, from time to time, enter into such further agreements with the Trustee or other parties and make such amendments to said Trust Agreement as it may deem necessary or desirable to carry out this Plan. Any and all rights or benefits which may accrue to a person under this Plan shall be subject to all the terms and provisions of the Trust Agreement.

17.02 Investment Of Trust Assets. The Trustee shall have full discretion and authority with regard to the investment of the Trust, except with respect to a Plan asset under the control or direction of a properly appointed Investment Manager or with respect to a Plan asset subject to Committee direction of investment. The Committee shall have the right to direct the Trustee with respect to the investment and re-investment of Plan assets and to appoint one or more Investment Managers with control over some or all of such assets.

17.03 Fees And Expenses From Trust. The Trustee shall receive reasonable annual compensation as may be agreed upon from time to time between the Committee and the Trustee. The Trustee shall pay all expenses reasonably incurred by it or by the Employer, the Committee, or other professional advisers or administrators in the administration of the Plan from the Trust unless the Company or Related Employer pays the expenses. The Plan Administrator shall not treat any fee or expense paid, directly or indirectly, by the Company or a Related Employer as an Employer contribution.

17.04 Distribution Directions. If no one claims a payment or distribution made from the Trust, the Trustee shall promptly notify the Plan Administrator and shall dispose of the payment in accordance with the subsequent direction of the Plan Administrator.

17.05 Trust For Exclusive Benefit Of Participants Of The Plan And Their Beneficiaries. Except as otherwise provided herein, it shall be impossible under any circumstances at any time for any part of the corpus or income of the Trust to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their Beneficiaries.

ARTICLE XVIII

TOP HEAVY PROVISIONS

18.01 Minimum Benefit.

(a) Calculation Of Top Heavy Minimum Benefit.

If this Plan is Top Heavy in any Plan Year, the Plan guarantees a minimum benefit for each Non-Key Employee who is a Participant eligible for such benefit as provided by this Article XVIII. A Participant's Top Heavy minimum benefit is an annual benefit, payable as a straight life annuity, equal to the Participant's Compensation multiplied by the applicable percentage. The applicable percentage is 2% multiplied by the number (not exceeding 10) of Years of Top Heavy Service as a Non-Key Employee Participant in the Plan. A "Year of Top Heavy Service" is a Plan Year in which the Plan is Top Heavy and the Participant completes a Year of Service. If a Non-Key Employee participates in this Plan and in a Top Heavy Defined Contribution Plan included in the Required Aggregation Group, the minimum benefits shall be provided under this Plan.

(b) Special Rules.

For purposes of determining the Top Heavy minimum benefit under paragraph (a), the Plan Administrator shall calculate a Participant's Compensation by averaging a Participant's annual Compensation over 5 consecutive Compensation periods (or, if less, the number of years of participation). When determining whether Compensation periods are consecutive for purposes of averaging Compensation, the Committee shall disregard Compensation periods for which the Participant does not complete at least 1,000 Hours of Service. A Participant under this Section shall include an Employee who is otherwise eligible to participate in the Plan, but who receives no accrual or a partial accrual because of the level of his Compensation, because he is not employed on the last day of the accrual computation period, or because the Plan is integrated with Social Security. If the accrual computation period does not coincide with the Plan Year, a minimum benefit accrues with respect to each accrual computation period falling wholly or partly in a Plan Year in which the Top Heavy minimum benefit requirement applies.

(c) No Reduction Of Minimum Benefit.

If a Participant accrues an additional benefit for a Plan Year by reason of this Section, the Participant's Accrued Benefit shall never be less than the Accrued Benefit determined at the end of that Plan Year, irrespective of whether the Plan is a Top Heavy plan for any subsequent Plan Year. The Employer shall not impute Social Security benefits to determine whether the Plan has satisfied the Top Heavy minimum benefit requirement for a Participant, nor shall the Plan offset a Participant's Social Security benefit from his Accrued Benefit attributable to the Top Heavy minimum benefit requirement.

18.02 Determination Of Top Heavy Status.

The Plan is "Top Heavy" for a Plan Year if the Top Heavy ratio as of the Determination Date exceeds 60%. The Top Heavy ratio is a fraction, the numerator of which is the sum of the Present Value of Accrued Benefits of all Key Employees as of the Determination Date, the contributions due as of the Determination Date, and distributions made within the five (5) Plan Year period ending on the Determination Date, and the denominator of which is a similar sum determined for all Employees. The Plan Administrator shall calculate the Top Heavy ratio without regard to the Accrued Benefit of any Non-Key Employee who was formerly a Key Employee. The Plan Administrator shall calculate the Top Heavy ratio by disregarding the Accrued Benefit (including distributions, if

any, of the Accrued Benefit) of an individual who has not received credit for at least one Hour of Service with the Employer during the one-year period ending on the Determination Date. In addition, the Plan Administrator shall disregard any part of any Accrued Benefit distributed by reason of Termination of Service, death or Disability in the one-year period ending on the Determination Date and, for all other events, the five-year period ending on the Determination Date. The Plan Administrator shall determine Present Value of Accrued Benefits as of the most recent valuation date for computing minimum funding costs falling within the twelve month period ending on the Determination Date, whether or not the Actuary performs a valuation that year, except as Code Section 416 and the Treasury Regulations require for the first and second Plan Year of the Plan. The Plan Administrator shall calculate the Top Heavy ratio, including the extent to which it must take into account distributions, rollovers, and transfers, in accordance with Code Section 416 and the Treasury Regulations thereunder.

If the Employer maintains other qualified plans (including a simplified employee pension plan), this Plan is Top Heavy only if it is part of the Required Aggregation Group, and the Top Heavy ratio for both the Required Aggregation Group and the Permissive Aggregation Group exceeds 60%. The Plan Administrator shall calculate the Top Heavy ratio in the same manner as required by the first paragraph of this Section, taking into account all plans within the Aggregation Group. To the extent the Plan Administrator must take into account distributions to a Participant, the Plan Administrator shall include distributions from a terminated plan that would have been part of the Required Aggregation Group if it were in existence on the Determination Date. The Plan Administrator shall calculate the Present Value of accrued benefits and the other amounts the Plan Administrator must take into account under qualified plans included within the group in accordance with the terms of those plans, Code Section 416 and the Treasury Regulations thereunder. If an aggregated plan does not have a valuation date coinciding with the Determination Date, the Plan Administrator shall value the accrued benefits or accounts in the aggregated plan as of the most recent valuation date falling within the twelve-month period ending on the Determination Date except as required by Code Section 416 and applicable Treasury Regulations. The Plan Administrator shall calculate the Top Heavy ratio with reference to the Determination Dates that fall within the same calendar year.

The accrued benefit of a Participant other than a Key Employee shall be determined under the method, if any, that uniformly applies for accrual purposes under all defined benefit plans maintained by the Employer; or if there is no such method, then as if such benefit accrued not more rapidly than the slowest accrual rate permitted under the fractional rule of Code Section 411(b)(1)(C).

For purposes of valuing Accrued Benefits under this Plan and accrued benefits under any other defined benefit plan taken into account in the Top Heavy ratio, the Plan Administrator shall use the actuarial assumptions of Section 1.08.

18.03 Definitions.

For purposes of this Article, the following definitions apply:

(a) "Key Employee" - As of any Determination Date, a Key Employee is a Participant who is a "key employee" under the provisions of Code Section 416(i) and the Treasury Regulations thereunder.

(b) "Non-Key Employees" - An Employee who does not meet the definition of Key Employee.

(c) "Compensation" - Compensation as defined in Code Section 415(c)(3) (but limited pursuant to Code Section 401(a)(17)).

(d) "Required Aggregation Group" - Required Aggregation Group means:

(i) Each qualified plan of the Employer in which at least one (1) Key Employee participates at any time during the 5 Plan Year period ending on the Determination Date; and

(ii) Any other qualified plan of the Employer that enables a plan described in (i) above to meet the requirements of Code Section 401(a)(4) or Code Section 410.

The Required Aggregation Group includes any Plan of the Employer which was maintained within the last 5 years ending on the Determination Date on which a top heaviness determination is being made if such plan would otherwise be part of the Required Aggregation Group for the Plan Year but for the fact it has been terminated.

(e) "Permissive Aggregation Group" - The Permissive Aggregation Group is the Required Aggregation Group plus any other qualified plans maintained by the Employer, but only if such group would satisfy in the aggregate the requirements of Code Section 401(a)(4) and Code Section 410. The Plan Administrator shall determine which plans to take into account in determining the Permissive Aggregation Group.

(f) "Employer" – The Company and any Related Employers. The Employer and the Plan Administrator shall not aggregate ownership interests in more than one Related Employer to determine whether an individual is a Key Employee because of his ownership interest in the Employer.

(g) "Determination Date" - For any Plan Year, the Determination Date is the Accounting Date of the preceding Plan Year or, in the case of the first Plan Year of the Plan, the Accounting Date of that Plan Year.

18.04 Application of Article. Notwithstanding any other provisions of the Plan to the contrary, for any Plan Year in which the Plan is "Top Heavy," the provisions of this Article shall apply, but only to the extent required by Code Section 416. In the event that Congress should provide by statute, or the Treasury Department should provide by regulation or ruling, that the limitations provided in this Article are no longer necessary for the Plan to meet the requirements of Code Section 401 or other applicable law then in effect, such limitations in this Article shall become void and shall no longer apply, without necessity of further amendment to the Plan.

As provided in Code Section 416, the payment of the minimum benefit set forth in Section 18.01 shall not apply with respect to any Employee included in a unit of Employees covered by a collective bargaining agreement between Employee representatives and an Employer if retirement benefits were the subject of good faith bargaining between the Employee representatives and the Employer.

ARTICLE XIX

MISCELLANEOUS

19.01 Evidence. Anyone required to give evidence under the terms of the Plan may do so by certificate, affidavit, document or other information which the person to act in reliance may consider pertinent, reliable and genuine, and to have been signed, made or presented by the proper party or parties. The Committee and the Trustee shall be fully protected in acting and relying upon any evidence described under the immediately preceding sentence.

19.02 No Responsibility For Employer Action. Neither the Trustee nor the Committee shall have any obligation or responsibility with respect to any action required by the Employer, the Company, any Participant or eligible Employee, or for the failure of any of the above persons to act or make any payment or contribution, or to otherwise provide any benefit contemplated under this Plan, nor shall the Trustee or the Committee be required to collect any contribution required under the Plan, or to determine the correctness of the amount of any Employer contribution. Neither the Trustee nor the Committee need inquire into or be responsible for any action or failure to act on the part of the others, or on the part of any other person who has any responsibility regarding the management, administration or operation of the Plan, whether by the express terms of the Plan or by a separate agreement authorized by the Plan or by the applicable provisions of ERISA. Any action required of a corporate employer must be by its board of directors, an authorized committee thereof or by a duly authorized officer or other designate.

19.03 Fiduciaries Not Insurers. The Committee, the Plan Administrator, the Trustee, and the Employer in no way guarantee the Trust from loss or depreciation. The Employer does not guarantee the payment of any money which may be or becomes due to any person from the Trust. The liability of the Committee and the Trustee to make payment from the Trust at any time and all times is limited to the then available assets of the Trust.

19.04 Waiver Of Notice. Any person entitled to notice under the Plan may waive the notice, unless the Code or Treasury Regulations issued thereunder require the notice, or ERISA specifically or impliedly prohibits such a waiver.

19.05 Successors. The Plan shall be binding upon all persons entitled to benefits under it, their respective heirs and legal representatives, upon the Employer, its successors and assigns, and upon the Trustee, the Committee, the Plan Administrator and their successors.

19.06 Word Usage. Words used in the masculine also apply to the feminine or neuter where applicable, and wherever the context of the Plan dictates, the plural includes the singular and the singular includes the plural.

19.07 Headings. The headings of the Plan are for reference only. In the event of a conflict between a heading and the content of a Plan Section, the content of the Section of the Plan shall control.

19.08 Governing Law and Venue. In order to benefit Plan Participants by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 19.08 shall apply. Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana and of the United States for the Northern District of Indiana. The Company, each Related Employer that adopts the Plan, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such

parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

19.09 Employment Not Guaranteed. Nothing contained in this Plan, and nothing with respect to the establishment of the Trust, any modification or amendment to the Plan or Trust, the creation of any Accrued Benefit, or the payment of any benefit, shall give any Employee, Participant or any Beneficiary any right to continue employment, or any legal or equitable right against the Employer, an Employee of the Employer, the Plan Administrator, the Company, the Committee, the Trustee, or agents or employees of such individuals or entities. Nothing in the Plan shall be deemed or construed to impair or affect in any manner the right of the Employer, in its discretion, to hire Employees and, with or without cause, to discharge or terminate the service of Employees.

ARTICLE XX

EXCLUSIVE BENEFIT; AMENDMENT; TERMINATION

20.01 Exclusive Benefit. Except as otherwise provided herein, the Employer shall have no beneficial interest in any asset of the Trust and no part of any asset in the Trust may ever revert to or be repaid to the Employer, either directly or indirectly; nor prior to the satisfaction of all liabilities with respect to the Participants and their Beneficiaries under the Plan, shall any part of the corpus or income of the Trust Fund, or any asset of the Trust, be (at any time) used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Beneficiaries.

20.02 Amendment To Plan or Trust. The Committee shall have the right at any time, and from time to time:

(a) To amend this agreement in any manner deemed necessary or advisable in order to qualify (or maintain qualification of) this Plan and the Trust under the appropriate provisions of the Code; and

(b) To amend the Plan and the Trust in any other manner.

No amendment shall authorize or permit any part of the Trust Fund (other than the part which is required to pay taxes and administration expenses) to be used for or diverted to purposes other than the exclusive benefit of the Participants or their Beneficiaries or estates. No amendment shall cause or permit any portion of the Trust Fund to revert to or become a property of the Employer.

Furthermore, an amendment (including any restatement of the Plan) may not decrease a Participant's Accrued Benefit, except to the extent permitted under Code Section 412(c)(8), and may not reduce or eliminate any benefits protected under Code Section 411(d)(6), determined immediately prior to the later of the adoption date or effective date of the amendment. In general, benefits protected under Code Section 411(d)(6) include early retirement benefits or retirement-type subsidies and optional forms of benefit payments.

The Committee shall make all amendments in writing. Each amendment shall state the date to which it is effective. Each amendment shall state the date to which it is either retroactively or prospectively effective, and may be executed by an authorized member or other delegate of the Committee.

20.03 Amendment To Vesting Provisions. The Committee reserves the right to amend the vesting provisions of the Plan at any time. However, the Committee shall not apply any such amended vesting schedule to reduce the Vested percentage of any Participant's Accrued Benefit derived from Employer contributions (determined as of the later of the date the Company adopts the amendment, or the date the amendment becomes effective) to a percentage less than the Vested percentage computed under the Plan without regard to the amendment. An amended vesting schedule shall apply to a Participant only if the Participant receives credit for at least one Hour of Service after the new schedule becomes effective.

If the Committee makes a permissible amendment to the vesting provisions of the Plan, each Participant having at least 3 Years of Vesting Service with the Employer may elect to have the percentage of his Vested Accrued Benefit computed under the Plan without regard to the amendment. The Participant must file his election with the Employer within 60 days of the latest of (a) the Committee's adoption of the amendment; (b) the effective date of the amendment; or (c) the Participant's receipt of a copy of the amendment. The Employer, as soon as practicable, shall forward to each affected Participant a true copy of any amendment to the vesting provisions, together with an explanation of the effect of the amendment, the appropriate form upon which the Participant may make an election to remain under the vesting provisions provided under the Plan prior to the amendment, and notice of the time within which the Participant must make an election to remain under the prior vesting provisions. The election

described in this Section does not apply to a Participant if the amended vesting provisions provide for vesting at least as rapid at all times as the vesting provisions in effect prior to the amendment. For purposes of this Section, an amendment to the vesting provisions of the Plan includes any Plan amendment which directly or indirectly affects the computation of the Vested percentage of an Employee's rights to his Employer derived Accrued Benefit.

20.04 Merger/Direct Transfers And Elective Transfers. The Committee shall not consent to, or be a party to, any merger or consolidation with another plan, or to a transfer of assets or liabilities to another plan, unless immediately after the merger, consolidation or transfer, the surviving plan provides each Participant a benefit equal to or greater than the benefit each Participant would have received had the Plan terminated immediately before the merger, consolidation or transfer. The Trustee possesses the specific authority to enter into merger agreements or agreements for the direct transfer of assets with the trustee of other retirement plans described in Code Section 401(a), and to accept the direct transfer of plan assets, or to transfer Plan assets as a party to any such agreement, upon the consent or direction of the Committee.

If permitted by the Committee in its discretion, the Trustee may accept a direct transfer of plan assets on behalf of an Employee prior to the date the Employee becomes a Participant in the Plan. If the Trustee accepts such a direct transfer of plan assets, the Committee and Trustee shall treat the Employee as a Participant for all purposes of the Plan, except the Employee shall not accrue benefits until he actually becomes a Participant in the Plan.

Unless a transfer of assets to this Plan is an Elective Transfer, the Plan will preserve all Code Section 411(d)(6) protected benefits with respect to the transferred assets, in the manner described in Section 20.02. A transfer is an "Elective Transfer" if: (a) the transfer satisfies the first paragraph of this Section; (b) the transfer is voluntary, under a fully informed election by the Participant; (c) the Participant has an alternative that retains his Code Section 411(d)(6) protected benefits (including an option to leave his benefit in the transferor plan, if that plan is not terminating); (d) the transfer satisfies the applicable spousal consent requirements of the Code; (e) the transferor plan satisfies the joint and survivor notice requirements of the Code, if the Participant's transferred benefit is subject to those requirements; (f) the Participant has a right to immediate distribution from the transferor plan, in lieu of the Elective Transfer; (g) the transferred benefit is at least the greater of the single sum distribution provided by the transferor plan for which the Participant is eligible or the present value of the Participant's accrued benefit under the transferor plan payable at that plan's normal retirement age; (h) the Participant has a one hundred percent (100%) Vested interest in the transferred benefit; and (i) the transfer otherwise satisfies applicable Treasury Regulations. If this Plan accepts an Elective Transfer from a defined contribution plan, the Plan guarantees a benefit derived from that Elective Transfer equal to the value of the transferred amount, expressed as an annual benefit payable at Normal Retirement Age in the normal form of benefit described in Section 7.01 of the Plan. The Trustee shall distribute this guaranteed benefit attributable to the Elective Transfer at the same time and in the same manner as it distributes the Participant's Accrued Benefit, and the Committee shall treat the guaranteed benefit as part of the Participant's Accrued Benefit for purposes of valuing the Participant's Accrued Benefit under any consent or election requirements provided in the Plan. An Elective Transfer may occur between qualified plans of any type.

The Trustee shall hold, administer and distribute any transferred assets as a part of the Trust Fund, and the Trustee shall maintain a separate Transfer Account for the benefit of the Employee on whose behalf the Trustee accepted the transfer in order to reflect the value of the transferred assets.

Furthermore, a merger or direct transfer described in this Section of the Plan is not a termination for purposes of the special distribution provisions described in this Section.

20.05 Discontinuance. The Committee shall have the right, at any time, to suspend or discontinue the contributions of any Employer under the Plan, and to terminate, at any time, this Plan and the Trust. With respect to any specific Employer, the Plan shall terminate upon the first to occur of the following:

(a) The date terminated by action of the Committee.

(b) The date the Employers shall be judicially declared bankrupt or insolvent.

(c) The dissolution, merger, consolidation or reorganization of the Employer, or the sale by the Employer of all or substantially all of its assets, unless the successor or purchaser makes provision to continue the Plan, in which event the successor or purchaser must substitute itself as the Employer under this Plan.

20.06 Full Vesting On Termination. Notwithstanding any other provision of the Plan to the contrary, upon either full or partial termination of the Plan, an affected Participant's right to his Accrued Benefit shall be 100% Vested.

20.07 Partial Termination. Upon termination of the Plan with respect to a group of Participants which constitutes a partial termination of the Plan, the Trustee shall allocate and segregate for the benefit of the Employees then or theretofore employed by the Employer with respect to which the Plan is being terminated the proportionate interest of such Participants in the Trust Fund. Such proportionate interest shall be determined by the actuary for the Plan. The actuary shall make this determination on the basis of the contributions made by the Employer, the provisions of this Article and such other considerations as the actuary deems appropriate. The fiduciaries shall have no responsibility with respect to the determination of any such proportionate interest.

The funds so allocated and segregated shall be used by the Trustee to pay benefits to or on behalf of Participants in accordance with Section 20.09.

20.08 Termination. Upon termination of the Plan, the distribution provisions of the Plan shall remain operative, except that: (i) if the present value of the Participant's Vested Accrued Benefit does not exceed $5,000, the Committee shall direct the Trustee to distribute the Participant's Vested Accrued Benefit to him in a lump sum as soon as administratively practicable after the Plan terminates; and (ii) if the present value of the Participant's Vested Accrued Benefit exceeds $5,000, the Participant or the Beneficiary may, in addition to the distribution events permitted under the Plan, elect to have the Trustee commence distribution of his Vested Accrued Benefit (in accordance with Article VII, VIII or IX) as soon as administratively practicable after the Plan terminates.

To liquidate the Trust, the Committee may purchase an immediate or deferred annuity contract for each Participant which protects the Participant's distribution rights under the Plan, if the present value of the Participant's Vested Accrued Benefit exceeds $5,000.

The Trust shall continue until the Trustee, after written direction from the Committee, has distributed all of the benefits under the Plan. A resolution or amendment to freeze all future benefit accruals but otherwise to continue maintenance of this Plan is not a termination for purposes of this Section. Furthermore, a merger or direct transfer described in Section 20.04 of the Plan is not a termination for purposes of the special distribution provisions described in this Section

20.09 Distribution Upon Termination Of Trust Fund. Upon termination of the Plan in whole or in part, or upon termination of employment of a group of Participants constituting a partial termination of the Plan, each such Participant's Accrued Benefit based on his service, Credited Service and Compensation prior to the date of termination (and considering the Interest Crediting Rate set forth in Section 4.05(d) and 5.05(d)) shall become fully vested and Vested to the extent funded. In no event shall any Participant or Beneficiary have recourse to other than the Plan Trust, or if applicable, the Pension Benefit Guaranty Corporation.

In the case of a complete termination of the Plan, the assets then held in the Trust shall be allocated, after payment of all expenses of administration or liquidation, in the manner prescribed by ERISA Section 4044.

Notwithstanding the foregoing, in accordance with the provisions of Section 414(l) of the Code and Treasury Regulations promulgated thereunder, if the Plan is terminated within five years from December 31, 2012 (the date of the merger of the Subsidiary Plan in the Plan), the accrued benefit that would have been provided under the Subsidiary Plan on a termination basis as of December 31, 2012 shall be payable in a priority category higher than the priority category under ERISA Section 4044.

20.10 Manner Of Distribution. Subject to the foregoing provisions of this Article XX, distributions may be implemented through the continuance of the Trust, the creation of a new trust, the purchase of Nontransferable Annuity Contracts, distributions in cash, in securities or other assets in kind (based on their fair market value as of the date of distribution), or a combination thereof, subject to the requirements of the Pension Benefit Guaranty Corporation and as the Committee in its discretion shall determine.

20.11 Overfunding. If there are assets remaining after satisfying all liabilities to Participants and Beneficiaries upon termination of the Plan, the Trustee shall return the amount by which the Employer has overfunded the Plan to the Employer. The Employer shall instruct the Trustee regarding the amount of overfunding to be so returned.

20.12 Special Restriction On Benefit. In the event of Plan termination, the benefit of any Highly Compensated Employee (active or former) is limited to a benefit that is nondiscriminatory under Code Section 401(a)(4).

Benefits distributed to any of the twenty-five (25) most highly compensated active and former Highly Compensated Employees are restricted such that the annual payments are no greater than an amount equal to the payment that would be made on behalf of the Employee under a Single Life Annuity that is the Actuarial Equivalent of the sum of the Employee's Accrued Benefit and the Employee's other benefits under the Plan.

The preceding paragraph shall not apply if: (a) after payment of the benefit to an Employee described in the preceding paragraph, the value of Plan assets equals or exceeds one hundred ten percent (110%) of the value of current liabilities, as defined in Code Section 412(l)(7); or (b) the value of the benefits for an Employee described above is less than one percent (1%) of the value of current liabilities.

For purposes of this section, "benefit" includes loans in excess of the amount set forth in Code Section 72(p)(2)(A), any periodic income, any withdrawal values payable to a living Employee, and any death benefits not provided for by insurance on the Employee's life.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

IN WITNESS WHEREOF, this Amendment and Restatement of the NiSource Salaried Pension Plan is hereby executed on this 23rd day of December, 2014, by the duly authorized representative of the NiSource Benefits Committee, to be effective as of January 1, 2014.

NISOURCE BENEFITS COMMITTEE

By: _____

Its: VP, HR

Schedule I
List of Participating Employers

PARTICIPATING EMPLOYERS IN
THE NISOURCE SALARIED PENSION PLAN

Name of Participating Employer

1. NiSource Inc.
2. NiSource Corporate Services Company
3. NiSource Energy Technologies, Inc.
4. NiSource Gas Transmissions & Storage Company
5. Northern Indiana Public Service Company (NIPSCO)
6. Energy USA-TPC Corp.

Schedule II
Cash Balance Election Periods

This Schedule II sets forth the cash balance election periods offered under the Plan, as previously described in the Plan 2006 Restatement or as may be subsequently modified to reflect additional election periods offered under the Plan as determined by the Committee.

1. 2002 Choice Period -- Election of AB I Benefit. Except as otherwise provided below, each Participant who was an Eligible Employee as of December 31, 2001 (who was still a Participant as of June 30, 2002 and including any Participant receiving benefits under a short-term disability plan maintained by an Employer) was entitled to elect to have his accruals on and after January 1, 2002 determined under the AB I Benefit provisions of Article V. Any such election must have been made no later than June 30, 2002, became irrevocable as of that date, and was effective as of July 1, 2002, retroactive to January 1, 2002. The Participant made this election by giving notice at a time and in a manner specified by the Plan Administrator. If a Participant failed to make an election, the Participant's benefits shall be determined under the FAP Benefit provisions, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan.

   Notwithstanding the foregoing, a Participant was not entitled to make this election if he:

   (a) was a Union Employee and the collective bargaining agreement covering the Employee did not provide for participation in the AB I Benefit as of July 1, 2002;

   (b) was receiving required minimum distributions pursuant to Section 10.07 as of July 1, 2002;

   (c) was receiving pay continuation benefits as of July 1, 2002; or

   (d) was on an unpaid leave of absence as of July 1, 2002, which was not an Authorized Leave of Absence.

   For purposes of calculating benefits under the 2002 Choice Period, the Conversion Date for purposes of determining the Opening Balance, Pay-Based Credits and Interest Credits is January 1, 2002. The Conversion Date for purposes of calculating the Protected Benefit is June 30, 2002 (or Termination of Service, if earlier) (and considering Compensation as of December 31, 2001).

2. 2002 Choice Period – Involuntarily Terminated Participants. Notwithstanding subsection (1) above, each Participant who was involuntarily terminated by the Company between January 1, 2002 and March 31, 2002 was entitled to elect to have his Accrued Benefit as of his date of Termination of Service governed by the AB I Benefit provisions of Article V. Any such election must have been made prior to such Participant's Termination of Service, became irrevocable as of that date and was effective as of July 1, 2002, retroactive to January 1, 2002. The Participant made this election by giving notice at a time and in a manner specified by the Committee. If a Participant failed to make a timely election, the Participant's benefits shall be determined under the FAP Benefit provisions, except as otherwise provided pursuant to the eligibility or automatic conversion provisions (such as rehire provisions) provided in the Plan.

3. 2002 Choice Period – Bay State Participants. Notwithstanding subsection (1) above, each Participant who transferred from Bay State Gas Company to the Company between January 1, 1999 and March 31, 2002 and who participated in the Bay State Gas Company Pension Plan in effect immediately prior to the date of transfer ("Former Bay State Participant") was entitled to elect to have his accruals after January 1, 2002 determined under the AB I Benefit provisions of Article V. Such election must have been made no later

than October 31, 2002, became irrevocable as of such date and was effective as of November 1, 2002, retroactive to January 1, 2002. The Former Bay State Participant made this election by giving notice at a time and in a manner specified by the Committee. If a Former Bay State Participant failed to make a timely election, the Participant's benefits shall be determined under the FAP Benefit provisions, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan.

For purposes of calculating benefits under the 2002 Choice Period for Former Bay State Participants, the Conversion Date for purposes of determining the Opening Balance, Pay-Based Credits and Interest Credits is January 1, 2002. The Conversion Date for purposes of calculating the Protected Benefit is October 31, 2002 (or Termination of Service, if earlier) (and considering Compensation as of December 31, 2001).

4. 2006 Choice Period -- Election of AB II Benefit. Except as otherwise provided below, each Exempt Employee participating in the Plan as of October 1, 2005 who was participating as of January 1, 2006 (including any Exempt Employee receiving benefits under a short term disability plan maintained by an Employer) was entitled to elect to have his accruals on and after January 1, 2006 determined under the AB II Benefit provisions of Article IV. Any such election must have been made no later than December 14, 2005, became irrevocable as of that date, and was effective as of January 1, 2006. The Exempt Employee made this election by giving notice at a time and in a manner specified by the Plan Administrator. If an Exempt Employee failed to make a timely election, the Exempt Employee's benefits shall be determined under the FAP Benefit provisions or AB I Benefit provisions, as applicable, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan.

   Notwithstanding the foregoing, an Exempt Employee was not entitled to make this election, and, therefore, shall remain a Participant in the benefit option under which he is currently participating, if he:

   (a) was a Union Employee and the collective bargaining agreement covering the Employee did not provide for participation in the AB II Benefit provisions as of January 1, 2006;

   (b) was a Non-Exempt Employee;

   (c) was receiving required minimum distributions pursuant to Section 10.07 as of January 1, 2006;

   (d) was receiving pay continuation benefits as of January 1, 2006; or

   (e) was on an unpaid leave of absence as of January 1, 2006, which was not an Authorized Leave of Absence.

   For purposes of calculating benefits under the 2006 Choice Period, the Conversion Date for purposes of determining the Opening Balance, Pay-Based Credits and Interest Credits is January 1, 2006. The Conversion Date for purposes of calculating the Protected Benefit is December 31, 2005 (or Termination of Service, if earlier).

5. Election After a Disability. Effective January 1, 2009, a Participant returning to active employment after a Disability shall be governed by the provisions of Section 3.04(d). Prior to January 1, 2009, a Participant returning to active employment after a Disability shall be subject to the cash balance election provisions set forth below.

(a) Disability During or After 2002 Choice Period. If a Participant to whom the AB I Benefit provisions otherwise apply was on a Disability leave and returned to work as an Eligible Employee, the Participant was entitled to elect to have his future accruals determined under AB I Benefit provisions. Any such Participant made this election within 90 days after the Participant's return to work as an Eligible Employee.

(b) Disability Under the AB II Benefit Provisions. If a Participant to whom the AB II Benefit provisions otherwise apply was on a Disability leave and returned to work as an Eligible Employee, the Participant was entitled to elect to have his future accruals determined under AB II Benefit provisions. Any such election must have been made no later than 90 days after such Participant returned to active employment with an Employer.

Any election pursuant to this subsection (5) became irrevocable as of the end of the applicable election period and was effective as of the date of return to active employment. The Participant made this election by giving notice in a manner specified by the Plan Administrator. If a Participant failed to make a timely election, the Participant's benefits shall be determined under the benefit provisions applicable during the period of Disability. For purposes of elections under this subsection (5), the Conversion Date was the first day of the month coincident with or next following the date of return to active employment, unless otherwise provided as set forth in the Plan 2006 Restatement.

6. Change in Status Election Periods. Effective January 1, 2009, a Participant experiencing a change in employment status due to a transfer shall be governed by the provisions of Section 3.04. Similarly, effective January 1, 2008, a Participant returning to active employment after a Termination of Service shall be governed by the provisions of Section 11.02. Prior to such dates, certain cash balance election provisions applied upon a change in employment status as set forth in the Plan 2006 Restatement. Accordingly, by way of example, but not limited hereto, the following election periods applied.

(a) Union Employees – AB I Elections. Notwithstanding subsection (1) above, each Employee in the Union Plan on or before December 31, 2001 who transferred to employment providing coverage under the Plan on or after January 1, 2002 was entitled to elect to have his accruals after such transfer determined under the AB I Benefit provisions of Article V. Any such election must have been made no later than 90 days after such Employee became eligible for coverage under the Plan. Such election took effect as of the date that was 12 months from the date of his transfer, with application retroactive to the date of transfer, provided that the Employee remained an Eligible Employee of the Plan as of such 12-month anniversary date. The Employee made this election by giving notice in a manner specified by the Plan Administrator. If such Participant failed to make a timely election, the Participant's benefits shall be determined under the FAP Benefit provisions, except as otherwise provided pursuant to a later election period or by the eligibility or automatic conversion provisions (such as transfer or rehire provisions) provided in the Plan.

(b) Non-Exempt to Exempt Transfers – AB II Elections. Any former Non-Exempt Employee who transferred employment to become an Exempt Employee between October 1, 2005 and December 31, 2008, was entitled to elect to have his future accruals determined under AB II Benefit provisions pursuant to a 90-day election period in a manner similar to the election period described in subsection (5) above.

Schedule III
Benefit Restrictions Pursuant to Code Section 436

This Schedule III sets forth the provisions relating to benefit restrictions that shall apply under Code Section 436 (as added by the Pension Protection Act of 2006) in the event of specified funding deficiencies under the Plan. These provisions shall operate only if the funding targets defined herein are not met and shall apply only for the duration of the applicable funding deficiency.

(a) **Effective Date and Application of Schedule.**

(1) Effective Date. The provisions of this Schedule apply to Plan Years beginning on or after January 1, 2008, provided that in the event the Plan is determined to be a collectively-bargained plan for purposes of Treasury Regulations Section 1.436-1(a)(5)(ii)(B), the provisions of this Schedule apply to Plan Years beginning on or after the earlier of (a) January 1, 2010 or (b) the later of (1) the date on which the last collective bargaining agreement relating to the Plan and ratified before January 1, 2008 terminates, without regard to extensions agreed to after August 17, 2006, or (2) January 1, 2008.

(2) Notwithstanding anything in this Schedule III to the contrary, the provisions of Code Section 436 and the Regulations thereunder are incorporated herein by reference.

(b) **Funding-Based Limitation on Shutdown Benefits and Other Unpredictable Contingent Event Benefits**

(1) In general. If a Participant is entitled to an "unpredictable contingent event benefit" payable with respect to any event occurring during any Plan Year, then such benefit may not be provided if the "adjusted funding target attainment percentage" for such Plan Year is:

(A) less than sixty percent (60%); or

(B) would be less than sixty percent (60%) percent taking into account such occurrence.

(2) Exemption. Paragraph (1) shall cease to apply with respect to any Plan Year, effective as of the first day of the Plan Year, upon payment by the Employer of a contribution (designated at the time of contribution as being for the purpose of avoiding the limitation of paragraph (1) and in addition to any minimum required contribution under Code Section 430) equal to:

(A) in the case of (b)(1)(A) above, the amount of the increase in the funding target of the Plan (under Code Section 430) for the Plan Year attributable to the occurrence referred to in paragraph (1), and

(B) in the case of (b)(1)(B) above, the amount sufficient to result in an "adjusted funding target attainment percentage" of sixty percent (60%).

(3) Unpredictable contingent event benefit. For purposes of this subsection, the term "unpredictable contingent event benefit" means any benefit payable solely by reason of:

(A) a plant shutdown (or similar event, as determined by the Secretary of the Treasury), or

(B) an event other than the attainment of any age, performance of any service, receipt or derivation of any compensation, or occurrence of death or disability.

(c) **Limitations on Plan Amendments Increasing Liability for Benefits**

(1) In general. No amendment which has the effect of increasing liabilities of the Plan by reason of increases in benefits, establishment of new benefits, changing the rate of benefit accrual, or changing the rate at which benefits become nonforfeitable may take effect during any Plan Year if the "adjusted funding target attainment percentage" for such Plan Year is:

(A) less than eighty percent (80%); or

(B) would be less than eighty percent (80%) taking into account such amendment.

(2) Exemption. Paragraph (1) above shall cease to apply with respect to any Plan Year, effective as of the first day of the Plan Year (or if later, the effective date of the amendment), upon payment by the Employer of a contribution (designated at the time of contribution as being for the purpose of avoiding the limitation of paragraph (1) and in addition to any minimum required contribution under Code Section 430) equal to--

(A) in the case of paragraph (c)(1)(A) above, the amount of the increase in the funding target of the Plan (under Code Section 430) for the Plan Year attributable to the amendment, and

(B) in the case of paragraph (c)(1)(B) above, the amount sufficient to result in an "adjusted funding target attainment percentage" of eighty percent (80%).

(3) Exception for certain benefit increases. Paragraph (1) shall not apply to any amendment which provides for an increase in benefits under a formula which is not based on a Participant's compensation, but only if the rate of such increase is not in excess of the contemporaneous rate of increase in average wages of Participants covered by the amendment.

(d) **Limitations on Accelerated Benefit Distributions**

(1) Funding percentage less than sixty percent (60%). If the Plan's "adjusted funding target attainment percentage" for a Plan Year is less than sixty percent (60%), then the Plan may not pay any "prohibited payment" with a Benefit Commencement Date on or after the applicable Section 436 measurement date (as defined in the final regulations under Code Section 436, hereinafter "Section 436 Measurement Date") for the Plan Year.

(2) Bankruptcy. During any period in which the Employer is a debtor in a case under Title 11, United States Code, or similar Federal or State law, the Plan may not pay any "prohibited payment." The preceding sentence shall not apply on or after the date on which the enrolled actuary of the Plan certifies that the "adjusted funding target attainment percentage" of the Plan for the Plan Year is not less than one hundred percent (100%).

(3) Limited payment if percentage at least sixty percent (60%) but less than eighty percent (80%) percent.

(A) In general. If the Plan's "adjusted funding target attainment percentage" for a Plan Year is sixty percent (60%) or greater but less than eighty percent (80%), then the Plan may not pay any "prohibited payment" with a Benefit Commencement Date on or after the applicable Section 436 Measurement Date for the Plan Year to the extent the amount of the payment exceeds the lesser of:

(i) fifty (50) percent of the amount of the payment which could be made without regard to this subsection, or

(ii) the present value (determined under guidance prescribed by the Pension Benefit Guaranty Corporation, using the interest and mortality assumptions under Code Section 417(e)) of the maximum guarantee with respect to the participant under ERISA Section 4022.

(B) One-time application.

(i) In general. Only one "prohibited payment" meeting the requirements of subparagraph (A) may be made with respect to any Participant during any period of consecutive Plan Years to which the limitations under either paragraph (1) or (2) or this paragraph applies.

(ii) Treatment of beneficiaries. For purposes of this subparagraph, a Participant and any Beneficiary (including an alternate payee, as defined in Code Section 414(p)(8)) shall be treated as one Participant. If the Accrued Benefit of a Participant is allocated to such an alternate payee and one or more other persons, the amount under subparagraph (A) shall be allocated among such persons in the same manner as the Accrued Benefit is allocated unless the qualified domestic relations order (as defined in Code Section 414(p)(1)(A)) provides otherwise.

(4) "Prohibited payment." For purposes of this subsection, the term "prohibited payment" means:

(A) any payment, based on the optional form of benefit elected, in excess of the monthly amount paid under a single life annuity (plus any Social Security supplements described in the last sentence of Code Section 411(a)(9)), to a Participant or Beneficiary whose Benefit Commencement Date occurs during any period a limitation under paragraph (1) or (2) is in effect.

(B) any payment for the purchase of an irrevocable commitment from an insurer to pay benefits, and

(C) any other payment specified by the Secretary by Regulations.

Such term shall not include the payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Participant.

(5) The limitations under this subsection (d) shall not apply to prohibited payments that are made to carry out the termination of the Plan in accordance with Section 20.08 and applicable law.

(6) Payment options in event of application of subsection (d). In the event the restrictions applicable under subsection (d) above become effective for the Plan as of an applicable

Section 436 Measurement Date and, as a result of such restrictions, an optional form of benefit that is otherwise available under Section 10.03 of the Plan is not available as of a Participant's Benefit Commencement Date, the Participant (or, if applicable, his Beneficiary) may elect to:

(A) commence benefits with respect to the entire Accrued Benefit under the Plan in any other optional form of benefit (available under Section 10.03 at the same Benefit Commencement Date) that is not restricted and satisfies paragraph (3)(A) above;

(B) defer commencement of the payment of the Accrued Benefit (either in whole or solely with respect to the portion restricted under paragraph (3)) to the extent such deferral is permitted under the Plan in and accordance with the applicable qualification requirements, including Code Sections 411(a)(11) and 401(a)(9); or

(C) with respect to optional forms of benefit restricted under paragraph (3) above, receive the unrestricted portion of that elected optional form of benefit as of the elected Benefit Commencement Date and either receive the remaining restricted portion in an optional form of benefit at the same Benefit Commencement Date that would be permitted under subsection (d) or defer receipt as provided in subparagraph (B) above.

(e) **Limitation on Benefit Accruals for Plans with Severe Funding Shortfalls**

(1) In general. If the Plan's "adjusted funding target attainment percentage" for a Plan Year is less than sixty percent (60%), benefit accruals under the Plan shall cease as of the applicable Section 436 Measurement Date for the Plan Year.

(2) Exemption. Paragraph (1) shall cease to apply with respect to any Plan Year, effective as of the first day of the Plan Year, upon payment by the Employer of a contribution (designated at the time of contribution as being for the purpose of avoiding the limitation of paragraph (1) and in addition to any minimum required contribution under Code Section 430) equal to the amount sufficient to result in an "adjusted funding target attainment percentage" of sixty percent (60%).

(3) Temporary modification of limitation. In the case of the first Plan Year beginning during the period beginning on October 1, 2008, and ending on September 30, 2009, the provisions of paragraph (1) above shall be applied by substituting the Plan's "adjusted funding target attainment percentage" for the preceding Plan Year for such percentage for such Plan Year, but only if the "adjusted funding target attainment percentage" for the preceding year is greater.

(f) **Rules Relating to Contributions Required to Avoid Benefit Limitations**

(1) Security may be provided.

(A) In general. For purposes of this section, the "adjusted funding target attainment percentage" shall be determined by treating as an asset of the Plan any security provided by the Employer in a form meeting the requirements of subparagraph (B).

(B) Form of security. The security required under subparagraph (A) shall consist of:

(i) a bond issued by a corporate surety company that is an acceptable surety for purposes of ERISA Section 412,

(ii) cash, or United States obligations which mature in three (3) years or less, held in escrow by a bank or similar financial institution, or

(iii) such other form of security as is satisfactory to the Secretary and the parties involved.

(C) Enforcement. Any security provided under subparagraph (A) may be perfected and enforced at any time after the earlier of:

(i) the date on which the Plan terminates,

(ii) if there is a failure to make a payment of the minimum required contribution for any Plan Year beginning after the security is provided, the due date for the payment under section 430(j), or

(iii) if the "adjusted funding target attainment percentage" is less than sixty percent (60%) for a consecutive period of 7 years, the valuation date for the last year in the period.

(D) Release of security. The security shall be released (and any amounts thereunder shall be refunded together with any interest accrued thereon) at such time as the Secretary may prescribe in Regulations, including Regulations for partial releases of the security by reason of increases in the "adjusted funding target attainment percentage."

(2) Prefunding balance or funding standard carryover balance may not be used as a contribution to avoid limitations. No prefunding balance or funding standard carryover balance under Code Section 430(f) may be used under subsection (b), (c), or (e) as a contribution to satisfy any payment an Employer may make under any such subsection to avoid or terminate the application of any limitation under such subsection.

(3) Deemed reduction of funding balances:

(A) In general. Subject to subparagraph (B), in any case in which a benefit limitation under subsection (b), (c), (d), or (e) would (but for this subparagraph and determined without regard to subsection (b)(2), (c)(2), or (e)(2)) apply to such Plan for the Plan Year, the Employer shall be treated for purposes of this title as having made an election under Code Section 430(f) to reduce the prefunding balance or funding standard carryover balance by such amount as is necessary for such benefit limitation to not apply to the Plan for such Plan Year. Notwithstanding the foregoing, with respect to subsections (b), (c) or (e), such deemed election shall be optional for any year in which the Plan is not a collectively-bargained plan as determined under Treasury Regulations Section 1.436-1(a)(5)(ii)(B).

(B) Exception for insufficient funding balances. Subparagraph (A) shall not apply with respect to a benefit limitation for any Plan Year if the application of subparagraph (A) would not result in the benefit limitation not applying for such Plan Year.

(g) **Presumed Underfunding for Purposes of Benefit Limitations**

(1) Presumption of continued underfunding. In any case in which a benefit limitation under subsection (b), (c), (d), or (e) has been applied to a Plan with respect to the Plan Year preceding the current Plan Year, the "adjusted funding target attainment percentage" of the Plan for the current Plan Year shall be presumed to be equal to the "adjusted funding target attainment percentage" of the Plan for the preceding Plan Year until the enrolled actuary of the Plan certifies the actual "adjusted funding target attainment percentage" of the Plan for the current Plan Year.

(2) Presumption of underfunding after 10th month. In any case in which no certification of the "adjusted funding target attainment percentage" for the current Plan Year is made with respect to the Plan before the first day of the 10th month of such year, for purposes of subsections (b), (c), (d), and (e), such first day shall be deemed, for purposes of such subsection, to be a Section 436 Measurement Date of the Plan for the current Plan Year and the Plan's "adjusted funding target attainment percentage" shall be conclusively presumed to be less than sixty percent (60%) as of such first day.

(3) Presumption of underfunding after 4th month for nearly underfunded plans. In any case in which:

(A) a benefit limitation under subsection (b), (c), (d), or (e) did not apply to a Plan with respect to the Plan Year preceding the current Plan Year, but the "adjusted funding target attainment percentage" of the Plan for such preceding Plan Year was not more than ten (10) percentage points greater than the percentage which would have caused such subsection to apply to the Plan with respect to such preceding Plan Year, and

(B) as of the first day of the 4th month of the current Plan Year, the enrolled actuary of the Plan has not certified the actual "adjusted funding target attainment percentage" of the Plan for the current Plan Year, until the enrolled actuary so certifies, such first day shall be deemed, for purposes of such subsection, to be a Section 436 Measurement Date of the Plan for the current Plan Year and the "adjusted funding target attainment percentage" of the Plan as of such first day shall, for purposes of such subsection, be presumed to be equal to ten (10) percentage points less than the "adjusted funding target attainment percentage" of the Plan for such preceding Plan Year.

(h) **Treatment of Plan as of Close of Prohibited or Cessation Period.** The following provisions apply for purposes of applying this Section.

(1) Operation of Plan after period. Payments and accruals will resume effective as of the day following the close of the period for which any limitation of payment or accrual of benefits under subsection (d) or (e) applies.

(2) Treatment of affected benefits. Nothing in this subsection shall be construed as affecting the Plan's treatment of benefits which would have been paid or accrued but for this Section.

(3) Restoration of accruals. Notwithstanding the foregoing, any restoration of accruals that were limited under subsection (e) shall be treated as a plan amendment subject to the restrictions of subsection (c), except where the period of limitation of accruals under

subsection (e) applied for a period of 12 months or less and the "adjusted funding target attainment percentage" after restoration of accruals is at least 60%.

(4) Effective date of plan amendments. If a plan amendment does not go into effect as of its effective date during a Plan Year due to the restrictions of subsection (c), but is permitted to take effect later in the Plan Year due to the cessation of such limitation, the amendment shall be effective as of the later of the first day of the Plan Year or the effective date of the amendment. If the amendment cannot take effect during such Plan Year, it shall be effective as of the earliest date permitted pursuant to the rules of Code Section 436(c).

(i) **Definitions.**

(1) The term "funding target attainment percentage" has the same meaning given such term by Code Section 430(d)(2), except as otherwise provided herein. However, in the case of Plan Years beginning in 2008, the "funding target attainment percentage" for the preceding Plan Year may be determined using such methods of estimation as the Secretary may provide.

(2) The term "adjusted funding target attainment percentage" means the "funding target attainment percentage" which is determined under paragraph (1) by increasing each of the amounts under subparagraphs (A) and (B) of Code Section 430(d)(2) by the aggregate amount of purchases of annuities for employees other than highly compensated employees (as defined in Code Section 414(q)) which were made by the Plan during the preceding two (2) Plan Years.

(3) Application to plans which are fully funded without regard to reductions for funding balances.

(A) In general. In the case of a Plan for any Plan Year, if the "funding target attainment percentage" is one hundred percent (100%) or more (determined and without regard to the reduction in the value of assets under Code Section 430(f)(4)), the "funding target attainment percentage" for purposes of paragraphs (1) and (2) shall be determined without regard to such reduction.

(B) Transition rule. Subparagraph (A) shall be applied to Plan Years beginning after 2007 and before 2011 by substituting for "one hundred percent (100%)" the applicable percentage determined in accordance with the following table:

In the case of a Plan Year beginning in calendar year:	The applicable percentage is:
2008	92%
2009	94%
2010	96%

(C) Limitation of transition rule. Subparagraph (B) shall not apply with respect to the current Plan Year unless, for each Plan Year beginning on or after January 1, 2008 and before the current Plan Year, the "funding target attainment percentage" (determined without regard to the reduction in the value of assets under Code Section 430(f)(4)) of the Plan for each preceding Plan Year beginning after 2007 was not less than the applicable percentage with respect to such preceding Plan Year determined under subparagraph (B).

Appendix A – Survivor Annuity Calculations for FAP Benefit

NiSource Salaried Pension Plan

Percentage of Single Life Annuity Computed in Accordance
With Article VI Which is Payable to the Employee
and if the Spouse is to Receive a
Survivorship Annuity for Life After the Employee's Death

Spouse's Age Relative to Employee's Age	50% Survivor Annuity To Spouse	75% Survivor Annuity To Spouse	100% Survivor Annuity To Spouse
20 or more YEARS YOUNGER	75.00%	67.00%	60.00%
19	76.00	68.00	61.00
18	77.00	69.00	62.00
17	78.00	70.00	63.00
16	79.00	71.00	64.00
15	80.00	72.00	65.00
14	81.00	73.00	66.00
13	82.00	74.00	67.00
12	83.00	75.00	68.00
11	84.00	76.00	69.00
10	85.00	77.00	70.00
9	86.00	78.00	71.00
8	87.00	79.00	72.00
7	88.00	80.00	73.00
6	89.00	81.00	74.00
5	90.00	82.00	75.00
4	91.00	83.00	76.00
3	92.00	84.00	77.00
2	93.00	85.00	78.00
1	94.00	86.00	79.00
SAME AGE	95.00	87.00	80.00
1 YEAR(S) OLDER	95.25	87.50	80.75
2	95.50	88.00	81.50
3	95.75	88.50	82.25
4	96.00	89.00	83.00
5	96.25	89.50	83.75
6	96.50	90.00	84.50
7	96.75	90.50	85.25
8	97.00	91.00	86.00
9	97.25	91.50	86.75
10 or more	97.50	92.00	87.50

Appendix B – Early Retirement Incentive Program (Retirements Effective March 1, 1990)

1. The provisions of this Appendix B shall be applicable to each Participant who:

   (a) on or before August 1, 1990, is or shall be at least 55 years of age and whose combination of years of age and years of Credited Service under the Plan totals at least 85, and

   (b) elects between January 29, 1990 and February 9, 1990, except as extended in the reasonable discretion of the Committee, to retire effective March 1, 1990.

2. The Early Retirement reduction for payment prior to age 65 as specified in Section 7.03(b)(ii)(A) of the Plan shall be 0%, subject to any limitations imposed by Section 415 of the Code.

3. The applicable factor under the 50% survivorship annuity to Spouse in Appendix A of the Plan shall be 100%.

4. A Participant who has not yet reached age 60 at his date of Retirement shall qualify for a pro rata supplement to the first day of the month in which the Participant reaches age 65, based on the supplement described in Section 6.03 of the Plan, said supplement to be calculated as follows:

   Multiply the applicable supplement as calculated pursuant to Section 6.03 times a fraction, the numerator of which is 59, and the denominator of which is the number of months from the date of the Participant's Retirement to the first day of the month in which the Participant reaches age 65.

Appendix C -- Special Early Retirement Benefits (1990-1997)

1. The provisions of this Appendix C shall be applicable to each Participant who satisfies the requirements of (a) or (b) below. Any such Participant shall be permitted to retire in accordance with the provisions of this Appendix C. This Appendix C shall apply to:

   (a) Any Participant in the Plan who

      (i) retires on or after June 1, 1990 and before May 31, 1991, and

      (ii) has attained age 55, and the sum of his age plus his years of Credited Service equals 90 or more, or

   (b) Any Participant in the Plan who

      (i) retires on or after June 1, 1991 and on or before June 1, 1997, and

      (ii) has attained age 55, and the sum of his age plus his years of Credited Service equals 85 or more.

2. The Early Retirement reduction for payment prior to the Participant's Normal Retirement Date as specified in Section 7.03(b)(ii)(A) of the Plan shall be 0%, subject to any limitations imposed by Section 415 of the Code.

3. A Participant who has not reached age 65 at the date of retirement shall qualify for a supplement until the first of the month in which the Participant reaches age 65, or if earlier, the date on which he becomes entitled to receive a Disability Insurance Benefit under the Social Security Act, as amended. If the Participant is at least age 60 at his date of retirement, the amount of his supplement shall be the amount described in Section 6.03 of the Plan. If the Participant is less than age 60 at the date of his retirement, the supplement described in Section 6.03 of the Plan shall be multiplied by a fraction, the numerator of which is 60, and the denominator of which is the number of supplemental payments the Participant would receive if he lived until the first of the month in which he reaches age 65.

Appendix D –Early Retirement Reduction Factors

The FAP Benefit Early Retirement Reduction for Any Deferred Vested Benefit and for Early Retirees with Less Than 25 Years of Service

Months	0	1	2	3	4	5
Years						
0	1.000	.995	.990	.985	.980	.975
1	.940	.935	.930	.925	.920	.915
2	.880	.875	.870	.865	.860	.855
3	.820	.815	.810	.805	.800	.795
4	.760	.755	.750	.745	.740	.735
5	.700	.697	.693	.690	.687	.683
6	.660	.657	.653	.650	.647	.643
7	.620	.617	.613	.610	.607	.603
8	.580	.577	.573	.570	.567	.563
9	.540	.537	.533	.530	.527	.523
10	.500					

	6	7	8	9	10	11
0	.970	.965	.960	.955	.950	.945
1	.910	.905	.900	.895	.890	.885
2	.850	.845	.940	.835	.830	.825
3	.790	.785	.780	.775	.770	.765
4	.730	.725	.720	.715	.710	.705
5	.680	.677	.673	.670	.667	.663
6	.640	.637	.633	.630	.627	.623
7	.600	.597	.593	.590	.587	.583
8	.560	.557	.553	.550	.547	.543
9	.520	.517	.513	.510	.507	.503

Appendix E -- Special Early Retirement Benefits (1996/1997)

1. The provisions of this Appendix E shall be applicable to each Participant who satisfies the following requirements:

   (a) The Participant must attain age 55 on or before January 31, 1997.

   (b) The Participant must complete at least ten years of Credited Service on or before January 31, 1997.

   (c) The sum of the Participant's age plus his years of Credited Service must equal 75 or more by January 31, 1997.

   (d) The Participant must elect retirement on February 1, 1997 by filing the appropriate forms with the Committee between December 3, 1996 and January 31, 1997, or the Participant must elect retirement on January 1, 1997 by filing the appropriate forms with the Committee between November 4, 1996 and December 3, 1996, or the Participant must elect retirement on December 1, 1996 by filing the appropriate forms with the Committee on or before November 7, 1996.

2. Each Participant who satisfies the above requirements shall be permitted to retire in accordance with the provisions of this Appendix E, and the following Special Early Retirement Benefits shall be available to such Participant:

   (a) The Early Retirement Benefit reduction for payment prior to a Participant's Normal Retirement Date, as specified in Section 7.03(b)(ii)(A) of the Plan, shall be 0%, subject to any limitations imposed by Section 415 of the Code.

   (b) A Participant who has not reached age 65 at the date of Retirement shall qualify for a supplement until the first day of the month in which the Participant reaches age 65, or if earlier, the date on which he becomes entitled to a Disability Insurance Benefit under the Social Security Act, as amended. If the Participant is at least age 60 at his date of retirement, the amount of his supplement shall be the amount described in Section 6.03 of the Plan. If the Participant is less than age 60 at the date of his retirement, the supplement described in Section 6.03 of the Plan shall be multiplied by a fraction, the numerator of which is 60, and the denominator of which is the number of supplemental payments the Participant would receive if he lived until the first day of the month in which he reaches age 65.

   (c) The 1996 incentive bonus of a Participant, that is payable in calendar year 1997, shall be included as Compensation and Taxable Compensation received by the Participant during his final month of employment with the Company and all Related Employers, for purposes of determining the amount of his annuity benefit.

   (d) All vacation pay of a Participant earned pursuant to the vacation policy of the Company or any Related Employer, for the 12-month period ending March 31, 1997, shall be included as Compensation and Taxable Compensation received by the Participant during his final month of employment with the Company and all Related Employers, for purposes of determining the amount of his annuity benefit.

(e) The lump sum in the amount of $5,000 paid to a Participant by the Company or a Related Employer, as part of the Special Voluntary Early Retirement Program pursuant to which the Participant retired, shall not be included as Compensation and Taxable Compensation received by the Participant for purposes of determining the amount of his annuity benefit.

Appendix F -- Special Early Retirement Benefits (2000)

1. Notwithstanding the provisions contained elsewhere in the Plan, the provisions of this Appendix F shall be applicable to each Participant who satisfies the following requirements:

   (a) The Participant must attain age 55 on or before December 31, 2000.

   (b) The Participant must complete at least ten years of Credited Service on or before December 31, 2000.

   (c) The sum of the Participant's age plus his years of Credited Service must equal 85 or more by December 31, 2000.

   (d) The Participant must not have been notified of his involuntary severance from employment by the Committee on or before October 15, 2000.

   (e) The Participant must elect Retirement on January 1, 2001 or, at the discretion of management, such later date as the Company deems appropriate, by filing the appropriate forms with the Committee between October 12, 2000 and November 25, 2000.

2. Each Participant who satisfies the above requirements shall be permitted to retire in accordance with the provisions of this Appendix F, and the following Special Early Retirement Benefits shall be available to such Participant:

   (a) The Early Retirement Benefit reduction for payment prior to a Participant's Normal Retirement Date, as specified in Section 7.03(b)(ii) of the Plan, shall be 0%, subject to any limitations imposed by Section 415 of the Code.

   (b) A Participant who has not reached age 65 at the date of Retirement shall qualify for a supplement until the first day of the month in which the Participant reaches age 65, or if earlier, the date on which he becomes entitled to a Disability Insurance Benefit under the Social Security Act, as amended. If the Participant is at least age 60 at his date of retirement, the amount of his supplement shall be the amount described in Section 6.03 of the Plan. If the Participant is less than age 60 at the date of his Retirement, the supplement described in Section 6.03 of the Plan shall be multiplied by a fraction, the numerator of which is 60, and the denominator of which is the number of supplemental payments the Participant would receive if he lived until the first day of the month in which he reaches age 65.

   (c) A Participant who meets the criteria described for the program in subsections (a) through (c) of Section 1 above, who has been notified of a severance from employment by the Committee on or before October 15, 2000, and who is not otherwise eligible for the benefits under the Program, may elect the benefits under the program in lieu of any other severance benefits available to him.

Appendix G -- Special Distribution Benefit (2002)

1. Notwithstanding the provisions contained elsewhere in the Plan, the provisions of this Appendix G shall be applicable to each Participant who satisfies the following requirements in subsections (a) through (e) below:

   (a) The Participant must attain age 60 on or before March 31, 2002.

   (b) The Participant must complete at least ten years of Credited Service on or before March 31, 2002.

   (c) The sum of the Participant's age and his years of Credited Service must equal 85 or more by March 31, 2002.

   (d) The Participant must not have been notified of his involuntary severance from employment by the Company on or before February 15, 2002.

   (e) The Participant must elect retirement on April 1, 2002.

2. Each Participant who satisfies the above requirements may elect to receive his FAP Benefit in the form of a single lump sum payment equal to the Actuarial Equivalent of his annuity benefit. Any such election made by a married Participant must also comply with the spousal consent requirements of Section 10.02.

COLUMBUS/1741211v 5

FIRST AMENDMENT
TO THE
NISOURCE SALARIED PENSION PLAN

Background Information

A. NiSource Inc. (the "Company") maintains the NiSource Salaried Pension Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee") has the power to amend and modify the Plan pursuant to Section 20.02 thereof.

C. On July 1, 2015 (the "Effective Date"), NiSource implemented the spin-off of its pipeline and transmission business, comprised of Columbia Pipeline Group, Inc. and its related entities, to become independent and non-related to NiSource (the "CPG Spin-Off").

D. The Committee desires to amend the introduction of the Plan, as of the Effective Date, to describe the CPG Spin-Off and address its impact on the Plan.

Plan Amendment

1. The portion of the introduction of the Plan entitled Plan Background, regarding the history of the Plan, is amended by the addition of the following paragraph, included at the end of the last sentence of the Plan Background section:

> Effective as of the July 1, 2015, NiSource implemented the spin-off of its pipeline and transmission business, comprised of the Columbia Pipeline Group, Inc. ("CPG") and its Related Employers (collectively, the "CPG Entities"), to become independent and non-related to NiSource (the "CPG Spin-Off"). Prior to July 1, 2015, Employees of the CPG Entities participated in either the Plan or the Columbia Energy Group Pension Plan (the "CEG Plan"). Effective July 1, 2015, in connection with the above-described corporate spin-off, the NiSource Benefits Committee, Plan Administrator and Named Fiduciary having amendment authority over the Plan and the CEG Plan, authorized the transfer of assets and liabilities of certain Participants and Former Participants in the Plan and/or the CEG Plan to the Columbia Pipeline Group Pension Plan (comprised of its component parts the Columbia Pipeline Group (CEG) Pension Plan and the Columbia Pipeline Group (NiSource Salaried) Pension Plan). Pursuant to said transfer and the existing terms of the Plan, effective July 1, 2015, the Plan terms no longer apply to the above-mentioned Participants.

2. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this First Amendment to the NiSource Salaried Pension Plan to be executed on its behalf, by one of its members duly authorized, to be effective July 1, 2015 or such other date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Date: 6/22/15

SECOND AMENDMENT
TO THE
NISOURCE SALARIED PENSION PLAN

Background Information

A. NiSource Inc. (the "Company") maintains the NiSource Salaried Pension Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee") has the power to amend the Plan pursuant to Section 20.02 thereof.

C. The Committee desires to amend the Plan effective as of June 1, 2016, to provide for benefit accruals under the Plan for employees in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459 for a negotiated period who would not otherwise be eligible to accrue benefits under the Plan, as negotiated pursuant to the Memorandum of Understanding (MOU), generally effective June 1. 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC and the Company with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019 (or as otherwise applicable under the MOU).

Plan Amendment

1. Section 1.23 of the Plan, defining "Eligible Employee," is hereby amended by the addition of the following paragraph, to follow the end of such Section, to read as follows:

> Notwithstanding the foregoing, for purposes of the Plan and accrual of benefits hereunder, Eligible Employee shall include any Employee employed in the role of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) for the period from June 1, 2016 to April 30, 2019 (or other such date as of which such Employees would otherwise be considered a Union Employee as a result of employment in such role) (hereinafter, "Damage Prevention Coordinator"), as negotiated in the Memorandum of Understanding resulting from collective bargaining with respect to such position between the United Steelworkers of America, Local 12775, AFL-CIO-CLC and the Company generally effective June 1, 2016 (the "DPC Memorandum of Understanding"), who was, immediately prior to June 1, 2016, both:
>
> (i) employed by the Employer or a Related Employer; and
> (ii) a Participant in the Plan.
>
> Such Employees shall be considered Eligible Employees under the Plan while employed in the position of Damage Prevention Coordinator between June 1, 2016 and April 30, 2019. On and after May 1, 2019, no

such Union Employee in the position of Damage Prevention Coordinator shall be eligible to participate in the Plan.

2. Effective January, 1 2016, Section 3.04(a)(iii) of the Plan, regarding transfers between the Union Plan and the Plan, is hereby amended by the addition of the following sentence at the end of such Section:

> The provisions of this subsection (iii) applicable with reference to a one-year period from the date of any transfer described in this subsection do not apply beyond the expiration of the collective bargaining agreement between the Company and Union Employees in effect from June 1, 2009 to May 31, 2014, such that any transfer from a position covered under the Union Plan to employment in a position covered under the Plan after such date shall result in the Employee ceasing to participate in the Union Plan as of the date of such transfer, the conversion of the Employee's accrued benefit in the Union Plan to an Opening Balance under the AB II Benefit of the Plan as provided in Section 4.03(b) as of the date of such transfer, and the participation of the Employee in the AB II Benefit of the Plan following the date of such transfer. Further, after such date, any transfer from employment covered under the Union Plan to employment covered under the Plan and back to the Union Plan within a one-year period shall be treated as a transfer to the Plan and a second transfer back to the Union Plan, with benefit accruals determined at each transfer.

3. Section 3.04 of the Plan, regarding transfers, is hereby amended by the addition of a new subparagraph (f) to the end of such Section, to read as follows:

> (f) Special Provisions Applicable Under DPC Memorandum of Understanding with respect to Damage Prevention Coordinators. Notwithstanding the foregoing or any other provisions of the Plan, in the event of a transfer of an Employee from an Eligible Employee position covered under the Plan to the position of Damage Prevention Coordinator on any date after June 1, 2016 (or other such date applicable under the DPC Memorandum of Understanding) and before May 1, 2019, such Employee shall remain subject to the pension benefit accrual method in effect for the Employee under the Plan immediately prior to the transfer. In the event of a transfer of a Next Gen Employee to the position of Damage Prevention Coordinator on any date after June 1, 2016 (or other such date applicable under the DPC Memorandum of Understanding) and before May 1, 2019, such Employee shall remain a Next Gen Employee while in the role of Damage Prevention Coordinator during such period. In the event of a transfer of an Employee from a position covered under the Union Plan or any other defined benefit pension plan of the Employer or Related Employer to the position of Damage Prevention Coordinator on any date after June 1, 2016 and before May 1, 2019, such Employee shall remain subject to the pension benefit accrual method in effect for the

Employee under the Union Plan or other applicable plan of the Employer or Related Employer immediately prior to the transfer.

In the event of a transfer of an Employee from the position of Damage Prevention Coordinator to a position within the Plan on any date after June 1, 2016 (or other such date applicable under the DPC Memorandum of Understanding) and before May 1, 2019, such Employee shall remain subject to the pension benefit accrual provision in effect for the Employee immediately prior to the date of such transfer, except that if such Employee accrued a benefit under the Union Plan while in the position of Damage Prevention Coordinator during such period noted above, such Employee's benefit accrual and any conversion of same shall be determined according to the generally applicable transfer provisions of this Section 3.04.

To the extent not otherwise provided under the terms of this paragraph (f), the provisions of this Section 3.04 shall continue to apply as necessary to carry out the provisions of the DPC Memorandum of Understanding.

4. Section 4.01(a) of the Plan, describing Participants entitled to an AB II Benefit, is hereby amended by the addition of the following paragraph at the end of such subsection, to read as follows:

Pursuant to Section 1.23 of the Plan, as amended effective June 1, 2016, this Article shall apply to any Employee employed in the position of Damage Prevention Coordinator as described in Section 1.23, as amended, on any date after June 1, 2016 (or other such date applicable under the DPC Memorandum of Understanding) and before May 1, 2019, who was previously eligible to accrue benefits under this Article immediately prior to employment in the position of Damage Prevention Coordinator.

5. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this Second Amendment to the NiSource Salaried Pension Plan to be executed on its behalf, by one of its members duly authorized, to be effective June 1, 2016 or such other date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Date: 12/21/16

NISOURCE POST-65
RETIREE MEDICAL PLAN

As Amended and Restated
Effective as of January 1, 2016

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Plan 1
1.02 Plan Components 1

ARTICLE II DEFINITIONS 1
2.01 "Adopted Child" 1
2.02 "Annual Enrollment Period" 1
2.03 "Available Post-65 Retiree Coverage Option" 1
2.04 "BSG" 1
2.05 "BSG Med Supp (Med Only) Option" 1
2.06 "BSG Med Supp Option" 1
2.07 "BSG Med Supp Multi-Union Option" 2
2.08 "Category of Coverage" 2
2.09 "Child" 2
2.10 "Claims Administrator" 2
2.11 "COBRA" 2
2.12 "COBRA Continuation Coverage" 2
2.13 "Code" 2
2.14 "Columbia Divested Company" 2
2.15 "Committee" 2
2.16 "Company" 2
2.17 "Co-Insurance" 2
2.18 "Consolidated Flex Plan" 2
2.19 "Contracted Provider" 2
2.20 "Co-Payment" 2
2.21 "Covered Employee" 2
2.22 "Covered Expense" 3
2.23 "Covered Participant" 3
2.24 "Covered Percentage" 3
2.25 "Covered Person" 3
2.26 "Covered Person Contribution" 3
2.27 "Covered Retiree Group" 3
2.28 "Covered Same-Sex Domestic Partner" 3
2.29 "CPG" 3
2.30 "CPG Related Employer" 3
2.31 "CPG Spin-Off" 3
2.32 "Deductible" 3
2.33 "Defined Dollar Subsidy" 3
2.34 "Dependent" 3
2.35 "Employee" 4
2.36 "Employer" 4
2.37 "ERISA" 5
2.38 "Exempt Employee" 5
2.39 "Family" 5
2.40 "Financially Interdependent" 5
2.41 "Foster Child" 5
2.42 "Full-Time Employee" 5

2.43 "Group Health Plan" 5
2.44 "HIPAA" 6
2.45 "HMO Option" 6
2.46 "Hospital" 6
2.47 "Injury" 6
2.48 "Legal Ward" 6
2.49 "MAP Deductible " 6
2.50 "MAP-Med Only Option" 6
2.51 "MAP Option" 6
2.52 "Maximum Allowed Amount" 6
2.53 "Medicaid" 6
2.54 "Medigap Med-Only Supplement Option" 6
2.55 "Medigap Supplement Option" 6
2.56 "Medically Necessary" 6
2.57 "Medicare" 7
2.58 "Medicare Supplement Option" 7
2.59 "NIPSCO" 7
2.60 "NIPSCO Medicare Supplement Option" 7
2.61 "NIPSCO Represented Retiree" 7
2.62 "No Coverage Option" 7
2.63 "Non-Represented" 7
2.64 "Other Insured Arrangement Option" 7
2.65 "Other Party" 7
2.66 "Out-of-Pocket Expense Limitation" 7
2.67 "Part-Time Employee" 7
2.68 "Participant" 7
2.69 "Physician" 7
2.70 "Plan" 8
2.71 "Plan Administrator" 8
2.72 "Plan Effective Date" 8
2.73 "Plan Year" 8
2.74 "Post-65 Retiree" 8
2.75 "Post-65 Retiree Coverage Option" 8
2.76 "Pre-65 Retiree" 8
2.77 "Pre-65 Retiree Plan Participant" 8
2.78 "Predecessor Medicare Supplement Option" 8
2.79 "Pregnancy" 8
2.80 "Qualified Beneficiary" 8
2.81 "Qualifying Event" 9
2.82 "Related Employer" 9
2.83 "Relative" 9
2.84 "Represented" 9
2.85 "Retiree" 9
2.86 "Same-Sex Domestic Partner" 10
2.87 "Separation Date" 11
2.88 "Sickness" 11
2.89 "Spouse" 11
2.90 "Status Change" 11
2.91 "Stepchild" 12
2.92 "Summary Plan Description" 12

ARTICLE III PARTICIPATION 12
3.01 Eligibility 12
3.02 Enrollment 12
3.03 Categories of Coverage 15
3.04 Election of a Post-65 Retiree Coverage Option 15
3.05 Election of a Category of Coverage 16

ARTICLE IV RETIREE COVERAGE 16
4.01 Participation in Particular Post-65 Retiree Coverage Options 16
4.02 Special Provisions Applicable to 2002 NiSource Organization Restructuring 18
4.03 Special Provisions Applicable to Certain Outsourced and Severed Employees 19
4.04 MAP Option 20
4.05 MAP-Med Only Option 22
4.06 Medicare Supplement Option 24
4.07 NIPSCO Medicare Supplement Option 26
4.08 Medigap Supplement Option 28
4.09 Medigap Med-Only Supplement Option 28
4.10 BSG Med Supp Multi-Union Option 28
4.11 BSG Med Supp (Med Only) Option 31
4.12 BSG Med Supp Option 34
4.13 Special Provisions Applicable to Post-65 Retirees Who Are Former Represented Employees 37

ARTICLE V HMO OPTION 37

ARTICLE VI OTHER INSURED ARRANGEMENT OPTION 37

ARTICLE VII PARTICIPANT PAYMENTS AND LIMITS 38
7.01 Deductible 38
7.02 Co-Insurance 38
7.03 Co-Payments 38
7.04 Out-of-Pocket Expense Limitation 38
7.05 Maximum Benefits 38

ARTICLE VIII CONTRIBUTIONS TO THE PLAN 38
8.01 Employer Contributions 38
8.02 Covered Person Contributions 38

ARTICLE IX PRESCRIPTION DRUG COVERAGE 39
9.01 General 39
9.02 Medicare Part D 39
9.03 Co-Payments, Co-Insurance and Deductibles 39
9.04 Definitions 40
9.05 Items Covered 40
9.06 Items Not Covered 41
9.07 Preauthorization 42

ARTICLE X EMPLOYEE ASSISTANCE PROGRAM COVERAGE 42
10.01 Benefits 42
10.02 Claim for Benefits 42

ARTICLE XI SUBROGATION 42
11.01 Subrogation 42
11.02 Right of Recovery 42
11.03 Application to Funds Recovered 42
11.04 Cooperation Required 42
11.05 First Lien Created 43
11.06 Constructive Trust 43
11.07 Personal Liability Created 43

ARTICLE XII NONDUPLICATION OF BENEFITS 44
12.01 General 44
12.02 Definitions 44
12.03 Application of the Rules 44
12.04 Plan As Primary Payor 45
12.05 Plan As Secondary Payor 45
12.06 When Other Plan Has No Nonduplication of Benefits Rules 45
12.07 Vehicle Coverage Limitation 45
12.08 If Medicare Is Involved 45

ARTICLE XIII ADMINISTRATION OF PLAN 47
13.01 Committee to Administer the Plan 47
13.02 The Committee 47
13.03 Powers of the Plan Administrator 48
13.04 Interpretative Authority 48
13.05 Appointment of the Claims Administrator 49

ARTICLE XIV CLAIMS FOR BENEFITS 49
14.01 Consideration of Initial Claim 49
14.02 If the Claims Administrator Denies the Initial Claim 50
14.03 Appeal to the Claims Administrator. 51
14.04 If the Claims Administrator Denies a Claim on Appeal 52
14.05 Appeal to the Claims Administrator of Pre- and Post-Service Claim Denials. 53
14.06 If the Claims Administrator Denies a Claim on Appeal 53
14.07 Limitations Upon Civil Actions 54
14.08 Construction of Article 54

ARTICLE XV TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE 54
15.01 Cessation of Participation 54
15.02 COBRA 55

ARTICLE XVI PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION 57
16.01 General 57
16.02 Permitted Uses and Disclosure 57
16.03 Disclosures to Company 57
16.04 Adequate Separation 58
16.05 Unauthorized Use or Disclosure 59
16.06 Special Amendatory Authority 59

ARTICLE XVII PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION 59
17.01 General 59
17.02 Duty of the Plan Sponsor 59

ARTICLE XVIII GENERAL EXCLUSIONS 60
18.01 General 60

ARTICLE XIX MISCELLANEOUS PROVISIONS 60
19.01 Assignment of Benefits 60
19.02 Information To Be Furnished 61
19.03 Limitation of Rights 61
19.04 Plan Not Contract 61
19.05 Fiduciary Operation 61
19.06 No Guaranty 61
19.07 Misrepresentation 61
19.08 Inadvertent Error 61
19.09 No Liability for Acts of Any Provider 61
19.10 Covered Persons Responsibilities 62
19.11 Right of Recovery 62
19.12 Governing Law and Venue 62
19.13 Severability 62
19.14 Participant Litigation 62
19.15 Counterparts 63
19.16 Notice 63
19.17 Extension of Plan to Related Employers. 63

ARTICLE XX FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 63
20.01 Plan Self-Insured 63
20.02 Participants' and Dependents' Rights Unsecured 63
20.03 Amendment 63
20.04 Termination 64
20.05 Collective Bargaining Agreement 64

SCHEDULE 1 POST-65 RETIREE BENEFIT PROGRAM MATRIX .....

ARTICLE I
INTRODUCTION

1.01 Purpose of Plan. NiSource Inc. (the "Company") established and maintained the NiSource Consolidated Flex Medical Plan, a component welfare plan of the NiSource Life and Medical Benefits Program, to provide group medical benefits for the participants and beneficiaries thereunder, including for certain Post-65 Retirees (as defined below) and their dependents who have attained age 65 and for certain dependents of Pre-65 Retirees (as defined below) who have attained age 65, under one or more Medicare supplement plan options. Effective September 1, 2010, the Company established the Plan (as defined below) for the purpose of merging and incorporating all such Medicare supplement plan options into a single retiree-only plan that shall be a separate employee welfare benefit plan for purposes of ERISA (as defined below). The Plan was amended and restated effective as of January 1, 2011, January 1, 2013, January 1, 2014, January 1, 2015, and July 1, 2015. This is an amended and restated version of the Plan, effective as of January 1, 2016, that reflects certain plan design changes.

1.02 Plan Components. The Plan has 11 components: the BSG Med Supp (Med Only) Option, the BSG Med Supp Option, the BSG Med Supp Multi-Union Option, the HMO Option, the MAP-Med Only Option, the MAP Option, the Medigap Med-Only Supplement Option, the Medigap Supplement Option, the NIPSCO Medicare Supplement Option, the Medicare Supplement Option and Other Insured Arrangements. Alternatively, a Post-65 Retiree, or a Pre-65 Retiree Plan Participant on behalf of his eligible dependent, may choose the No Coverage Option.

ARTICLE II
DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

2.01 "Adopted Child" means any child legally adopted by, or placed for adoption with, a Covered Participant or Covered Same-Sex Domestic Partner.

2.02 "Annual Enrollment Period" means the period selected by the Company each year during which time a Retiree may select an Available Post-65 Retiree Coverage Option to be effective for the following Plan Year.

2.03 "Available Post-65 Retiree Coverage Option" means, with respect to a Post-65 Retiree, a Post-65 Retiree's Dependent, or a Dependent of a Pre-65 Retiree Plan Participant, any Post-65 Retiree Coverage Option that is available to the Retiree's Covered Retiree Group, as indicated in Schedule 1 attached hereto.

2.04 "BSG" means Bay State Gas Company, a Massachusetts corporation.

2.05 "BSG Med Supp (Med Only) Option" means the BSG Medical Supplement Plan Option, without prescription drug coverage, offered to Retirees pursuant to Article IV.

2.06 "BSG Med Supp Option" means the BSG Medical Supplement Plan Option, with prescription drug coverage, offered to Retirees pursuant to Article IV.

2.07 **"BSG Med Supp Multi-Union Option"** means the BSG Medical Supplement Multi-Union Plan Option offered to Retirees pursuant to Article IV.

2.08 **"Category of Coverage"** means each of the coverage choices described in Section 3.03.

2.09 **"Child"** means an unmarried person who is either (1) a naturally born child of a Covered Participant; (2) an Adopted Child; (3) a Stepchild; (4) a Foster Child; (5) a Legal Ward who is dependent upon a Covered Participant or Covered Same-Sex Domestic Partner for at least 50% of his or her financial support and who may be claimed on the income tax return of the Covered Participant or Covered Same-Sex Domestic Partner as a dependent (without giving effect to the Legal Ward's gross income for such year); or (6) any person deemed by court order to be a Child for purposes of the Plan.

2.10 **"Claims Administrator"** means the person, persons or entity appointed by the Plan Administrator to process benefit claims pursuant to Section 13.05.

2.11 **"COBRA"** means Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.12 **"COBRA Continuation Coverage"** means continuation coverage to the extent required by COBRA.

2.13 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.14 **"Columbia Divested Company"** means any one of the following companies that previously was affiliated with a Related Employer: Columbia Energy Services Corp., Columbia Propane Corporation, Columbia Electric Corporation, Columbia LNG Corporation, Energy.com Corporation, Columbia Trans Communications, Commonwealth Propane, Columbia Propane LP, Columbia Petroleum Corporation, Columbia Natural Resources Inc., Hawg Hauling & Disposal Inc., Coal Gas, CS-42, Gas Development, New York Gas & Elec, Pittsburgh Market Division and Columbia Gas of West Virginia.

2.15 **"Committee"** means the NiSource Benefits Committee.

2.16 **"Company"** means NiSource Inc., a Delaware corporation.

2.17 **"Co-Insurance"** means the amount of a Covered Expense that remains the responsibility of a Covered Person.

2.18 **"Consolidated Flex Plan"** means the NiSource Consolidated Flex Medical Plan, a component welfare plan of the NiSource Life and Medical Benefits Program, together with any and all amendments and supplements thereto, and any and all restatements thereof, from time to time.

2.19 **"Contracted Provider"** means, with respect to the BSG Med Supp Multi-Union Option, the BSG Med Supp (Med Only) Option and the BSG Med Supp Option, a Physician or Hospital with whom the exclusive provider organization through which such Post-65 Retiree Coverage Options are offered has contracted.

2.20 **"Co-Payment"** means a flat dollar amount that a Covered Person must pay before an expense will be covered.

2.21 **"Covered Employee"** means an individual who is (or was) provided coverage under the Plan by virtue of being or having been an Employee, and includes a Retiree who is covered by the Plan.

2.22 **"Covered Expense"** means a service or supply, the Covered Percentage of which is paid for by the Plan, or which is subject to the applicable Deductible and Co-Insurance.

2.23 **"Covered Participant"** means a Participant or Pre-65 Retiree Plan Participant.

2.24 **"Covered Percentage"** means the percentage of a Covered Expense covered by the Plan.

2.25 **"Covered Person"** means a Post-65 Retiree or Dependent covered under the Plan, and includes a Qualified Beneficiary covered under the Plan.

2.26 **"Covered Person Contribution"** means the contribution required under Section 8.02.

2.27 **"Covered Retiree Group"** means a group of retirees described in Schedule 1 attached hereto in which a Retiree is a member, as determined by the Plan Administrator or its designee, in its sole discretion.

2.28 **"Covered Same-Sex Domestic Partner"** means a Same-Sex Domestic Partner covered under the Plan.

2.29 **"CPG"** means Columbia Pipeline Group, Inc., a Delaware corporation.

2.30 **"CPG Related Employer"** means, on and after the Separation Date, (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes CPG; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with CPG; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes CPG.

2.31 **"CPG Spin-Off"** means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG.

2.32 **"Deductible"** has the meaning set forth in Section 7.01.

2.33 **"Defined Dollar Subsidy"** means the Company's contribution toward the cost of coverage for certain Retirees, as described in Sections 4.01 and 4.02.

2.34 **"Dependent"** means:

(a) The Spouse of a Covered Participant, if not legally separated, who has attained age 65;

(b) The Same-Sex Domestic Partner of a Covered Participant, provided such Covered Participant retired after February 1, 2013, and provided the Same-Sex Domestic Partner has attained age 65;

(c) a person who satisfies the provisions of Section 15.01(b) of the Plan for continued coverage as a surviving dependent, subject to any other limitations on dependent status (e.g., the limiting age for eligibility of a Child) included in this Section 2.34;

(d) A Child of a Covered Participant or Covered Same-Sex Domestic Partner who has attained age 65, who satisfies the "dependency test" described in this Section 2.34 and who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the Child's disability, if requested by the Claims Administrator, is received by the Claims Administrator and is provided to the Claims Administrator every three

years, or more frequently if requested by the Claims Administrator; (2) the Child is dependent upon the Retiree (or Covered Same-Sex Domestic Partner, as the case may be) for financial support and maintenance; (3) the Post-65 Retiree continues to be covered by the Plan or the Pre-65 Retiree continues to be covered by the Consolidated Flex Plan; and (4) the Child's disability continues; or

(e) A Child of a Covered Participant or of a Covered Same-Sex Domestic Partner who has attained age 65 and is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient under ERISA, as having a right to participate in the Plan as a Dependent.

For purposes of this Section 2.34, a Child of a Covered Participant or of a Covered Same-Sex Domestic Partner satisfies the "dependency test" for a particular Plan Year if

(x) the Covered Participant or Covered Same-Sex Domestic Partner would be allowed a dependent exemption for such Child in computing his or her federal taxable income for such Plan Year, or

(y) each of the following conditions is satisfied: (1) such Child receives over half of his or her support during the Plan Year from his or her parents and is in the custody of one or both parents for more than half of the Plan 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 Plan 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 month of the Plan Year.

For purposes of the "dependency test" in clause (x) above, the Child's gross income for such Plan Year may be ignored in determining whether the Covered Participant or Covered Same-Sex Domestic Partner would be entitled to a dependent exemption for such Child for such Plan Year.

Notwithstanding any other provision of the Plan, but subject to the provisions of Section 15.01(b) regarding coverage for a surviving dependent and the COBRA-like continuation coverage provisions of Section 15.02(g), effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child shall be a Dependent eligible for coverage, or entitled to any benefits, under the Plan.

2.35 **"Employee"** means a regular or temporary employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee shall not be considered an Employee for any period during which he was not treated as an Employee by the Plan Administrator.

2.36 **"Employer"** means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer that maintains a group health plan providing medical benefits for its employees or retirees, or for whose employees or retirees such a plan is maintained, if such plan is not included as part of the Plan or as part of the Consolidated Flex Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its Employees or Retirees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an

"Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, Lake Erie Land Company shall not be an Employer under the Plan.

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

2.38 **"Exempt Employee"** means an Employee who is not entitled to overtime under the Fair Labor Standards Act, 29 U.S.C. § 201, et seq.

2.39 **"Family"** means a Participant and such Participant's covered Dependents.

2.40 **"Financially Interdependent"** means that a Covered Participant and another person satisfy any two of the following conditions:

(a) the Covered Participant designates such other person as the Covered Participant's beneficiary for employer-sponsored retirement or life insurance benefits;

(b) the Covered Participant designates such other person as the primary beneficiary under the Covered Participant's will;

(c) the Covered Participant designates such other person as the Covered Participant's attorney-in-fact under a durable power of attorney for health care;

(d) the Covered Participant and such other person have a common ownership or leasehold interest in real property;

(e) the Covered Participant and such other person have joint bank or credit accounts or joint investments; or

(f) the Covered Participant and such other person have joint liability for a mortgage, lease or loan.

2.41 **"Foster Child"** means a child legally placed in the custody of a Covered Participant or Covered Same-Sex Domestic Partner by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, who is receiving parental care from such Covered Participant or Covered Same-Sex Domestic Partner, and for whom such Covered Participant or Covered Same-Sex Domestic Partner is legally responsible to provide medical care.

2.42 **"Full-Time Employee"** means an Employee characterized by an Employer as a full-time employee who regularly works 40 or more hours per week or, with respect to a Represented Employee, who regularly works such other period of time that is specified in the collective bargaining agreement covering such Employee as constituting full-time status for purposes of the Consolidated Flex Plan.

2.43 **"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care

(directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

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

2.45 **"HMO Option"** means a Coverage Option offered through a health maintenance organization pursuant to Article V.

2.46 **"Hospital"** means an institution that, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians who are duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses. It is not, other than incidentally, a nursing home, or a place for rest or for the aged.

2.47 **"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 a Covered Person's body from an external force or contact.

2.48 **"Legal Ward"** means any Child for whom a Covered Participant or Covered Same-Sex Domestic Partner is legal guardian, provided that the Child is dependent on such Covered Participant or Covered Same-Sex Domestic Partner for principal support and maintenance.

2.49 **"MAP Deductible "** means the amount of Covered Expenses that must be incurred by a Covered Person in a Plan Year under the MAP Option or the MAP-Med Only Option before the Plan will pay benefits for such Covered Person. The MAP Deductible shall be determined by the Plan Administrator from time to time. As of January 1, 2015, the MAP Deductible is $100.

2.50 **"MAP-Med Only Option"** means the Medical Assistance Plan Option, without prescription drug coverage, offered to Retirees pursuant to Article IV.

2.51 **"MAP Option"** means the Medical Assistance Plan Option, with prescription drug coverage, offered to Retirees pursuant to Article IV.

2.52 **"Maximum Allowed Amount"** has the meaning given such term in the Consolidated Flex Medical Plan.

2.53 **"Medicaid"** means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

2.54 **"Medigap Med-Only Supplement Option"** means the Medigap Med-Only Supplement Option offered to Retirees pursuant to Articles IV and Article VI.

2.55 **"Medigap Supplement Option"** means the Medigap Supplement Option offered to Retirees pursuant to Articles IV and Article VI.

2.56 **"Medically Necessary"** means a service or supply ordered or prescribed by a Physician 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 the Covered Person's health status to result in information that could affect treatment, if a diagnostic procedure; and (3) no more costly than any alternative.

2.57 **"Medicare"** means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended.

2.58 **"Medicare Supplement Option"** means the Medicare Supplement Plan Option offered to Retirees pursuant to Article IV.

2.59 **"NIPSCO"** means Northern Indiana Public Service Company.

2.60 **"NIPSCO Medicare Supplement Option"** means the NIPSCO Medicare Supplement Option (formerly known as the Medicare-Plus Plan Option) offered to NIPSCO Represented Retirees pursuant to Article IV.

2.61 **"NIPSCO Represented Retiree"** means a Retiree who is a former NIPSCO Represented Employee.

2.62 **"No Coverage Option"** means an election not to become covered under a Post-65 Retiree Coverage Option.

2.63 **"Non-Represented"** means a Full-Time or Part-Time Employee or Retiree who is not covered by a collective bargaining agreement between an Employer and a union.

2.64 **"Other Insured Arrangement Option"** means any other fully-insured arrangement maintained by the Company.

2.65 **"Other Party"** includes, without limitation, any of the following:

(a) Any party or parties who cause a Sickness or Injury;

(b) Any insurer or other indemnifier of the party or parties who caused a Sickness or Injury;

(c) Any guarantor of the party or parties who cause a Sickness or Injury;

(d) A Covered Person's insurer;

(e) A workers' compensation insurer; or

(f) Any other person, entity, policy or plan that is liable or legally responsible in relation to a Covered Person's Sickness or Injury.

2.66 **"Out-of-Pocket Expense Limitation"** has the meaning set forth in Section 9.03.

2.67 **"Part-Time Employee"** means an Employee characterized by an Employer as a part-time employee who regularly works less than 40, hours per week or, with respect to a Represented Employee, who regularly works such other period of time that is specified in the collective bargaining agreement covering such Employee as constituting part-time status for purposes of the Consolidated Flex Plan.

2.68 **"Participant"** means a Post-65 Retiree who is a Covered Person.

2.69 **"Physician"** means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. 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 Physicians 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 the Plan shall be deemed to be a Physician.

2.70 **"Plan"** means the NiSource Post-65 Retiree Medical Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.72 **"Plan Effective Date"** means September 1, 2010.

2.73 **"Plan Year"** means the calendar year, except that the initial Plan Year shall be the period commencing September 1, 2010 and ending December 31, 2010.

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

2.75 **"Post-65 Retiree Coverage Option"** means the BSG Med Supp (Med Only) Option, the BSG Med Supp Option, the BSG Med Supp Multi-Union Option, the HMO Option, the MAP-Med Only Option, the MAP Option, the Medigap Med-Only Supplement Option, the Medigap Supplement Option, the NIPSCO Medicare Supplement Option, the Medicare Supplement Option and the Other Insured Arrangement Option.

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

2.77 **"Pre-65 Retiree Plan Participant"** means a Pre-65 Retiree who is properly enrolled in the Consolidated Flex Plan.

2.78 **"Predecessor Medicare Supplement Option"** means any Medicare supplement option maintained prior to the Plan Effective Date under the Consolidated Flex Plan or any predecessor plan, or under any other plan maintained by an Employer, that provided benefits for certain Post-65 Retirees or their dependents who had attained age 65 or for certain dependents of Pre-65 Retirees (as defined below) who had attained age 65.

2.79 **"Pregnancy"** means the condition of being pregnant and all conditions and/or complications resulting therefrom.

2.80 **"Qualified Beneficiary"** means:

(a) Any persons who were Covered Persons on the date immediately preceding a Qualifying Event as:

(1) A Covered Employee;

(2) A Covered Employee's Spouse; or

(3) A Dependent Child.

(b) In the case of a Qualifying Event described in subsection 2.81(d), a Retiree who retired on or before the date of substantial elimination of coverage and any other individual who,

on the day before such Qualifying Event, is a Covered Person as a Spouse, Dependent Child. or surviving Spouse.

2.81 **"Qualifying Event"** means any of the following that results in loss of coverage for a Qualified Beneficiary:

(a) The Covered Employee's death;

(b) The divorce or legal separation of the Covered Employee from the Covered Employee's Spouse;

(c) A Dependent Child is no longer an eligible Dependent; or

(d) With respect to a Retiree, a proceeding in a case under Title XI, United States Code, with respect to the Company. In the case of a Qualifying Event described in this subsection 2.81(d), a "loss of coverage" includes a substantial elimination of coverage with respect to a Qualified Beneficiary described in subsection 2.80(b) within one year before or after the date of commencement of the proceeding.

2.82 **"Related Employer"** means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.83 **"Relative"** means a person who is the Spouse, mother, father, sister, brother, Child or in-law of a Covered Participant.

2.84 **"Represented"** means a Full-Time or Part-Time Employee or a Retiree who is covered by a collective bargaining agreement between an Employer and a union.

2.85 **"Retiree"** means a former Full-Time Employee or Part-Time Employee who retired from service with an Employer, in accordance with a plan or procedure adopted by the Employer, after having attained the age of 55 years and ten Years of Service. 'Retiree' also means a former Full-Time Employee or Part-Time Employee who retired from service with an Employer, in accordance with a plan or procedure adopted by the Employer and after ten Years of Service, but prior to attaining the age of 55 years, and who elects continued coverage under the Plan in lieu of COBRA Continuation Coverage pursuant to a written agreement entered into with an Employer. For purposes of this Section 2.85, "Years of Service" has the same meaning given such term in Section 4.01(c)(3). Notwithstanding the foregoing,

(a) A person who would otherwise meet the definition of "Retiree" shall not cease to be a Retiree solely because such person is rehired by an Employer to regularly work less than twenty hours per week;

(b) "Retiree" shall also mean any former Employee who qualifies as a Retiree under the Special Provisions described in Article IV;

(c) Upon reaching age 65, a Retiree shall be considered a Post-65 Retiree;

(d) A person who would otherwise meet the definition of "Retiree" shall not be ineligible to be a Retiree solely because such person elected to retire from service with an Employer during a strike or lockout;

(e) "Retiree" shall include any person who satisfied the definition of "Retiree" that was in effect under the Plan or any predecessor plan at the time of such person's retirement; and

(f) "Retiree" shall not include any person who is not a member of a Covered Retiree Group or who belongs to a Covered Retiree Group for which there is no Available Post-65 Retiree Coverage Option.

Without limiting the generality of any other provision of the Plan, as of the Separation Date, the term 'Employer' for purposes of this Section 2.85 shall not include any Columbia Divested Company or any CPG Related Employer.

2.86 "Same-Sex Domestic Partner" means, with respect to a Covered Participant, a person of the same sex as the Covered Participant, if the Covered Participant and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is the Covered Participant's registered domestic partner, or is a party to a civil union with the Covered Participant, under the laws of the Covered Participant's state of residence; or

(b) The Covered Participant and such person

(1) are both age 18 or older and competent to enter into a legal contract;

(2) have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are Financially Interdependent;

(3) share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in the Covered Participant's state of residence;

(4) reside in a state that, prior to June 26, 2015, did not recognize or permit same-sex marriage, domestic partner registration or civil union;

(5) are not currently married to, a party to a civil union with, or the domestic partner, of any other person;

(6) intend that their same-sex domestic partnership be of unlimited duration; and

(7) do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

Notwithstanding the foregoing, for any insured benefit option, a person shall not be a Same-Sex Domestic Partner if he is otherwise ineligible for coverage under the terms of the certificate of coverage, group insurance policy or other governing document for such benefit option.

From time to time, a Covered Participant may be required to confirm orally, electronically or in writing, in a manner prescribed by the Plan Administrator, that the Covered Participant and his or her Same-Sex Domestic Partner satisfy the foregoing eligibility requirements.

2.87 **"Separation Date"** means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

2.88 **"Sickness"** means an illness causing loss commencing while the Plan is in force for a Covered Person. 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 Physician.

2.89 **"Spouse"** means a person who is treated as a spouse under the Code.

2.90 **"Status Change"** means any of the following:

(a) Legal Marital Status. Events that change a Retiree's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(b) Number of Dependents. Events that change a Retiree's number of Dependents, including birth, adoption, placement for adoption (as defined in Treasury Regulations under Code Section 9801), or death of a Dependent.

(c) Employment Status. A termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite that changes the employment status of a Retiree, a Spouse or other Dependent, or any other change in the employment status of a Retiree, a Spouse or other Dependent that makes such individual eligible or ineligible for coverage under the Plan (such as switching from full-time to part-time status or from salaried to hourly-paid).

(d) Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to marriage, attainment of age, student status, or any similar circumstance as provided in the Plan.

(e) Residence. A change in the place of residence of a Retiree, a Spouse or other Dependent.

(f) Other Permissible Events. Any other event that the Plan Administrator or a member of the Committee determines to be a permissible Status Change under the Code or any regulation, ruling or release issued thereunder. Such determination shall be (1) consistent with the terms of the Plan; and (2) made in a uniform and non-discriminatory manner.

As used in this Section 2.90, and subject to the immediately following paragraph, the term "Dependent" shall include only those Dependents described in Section 2.34 above who would be considered a "dependent" for purposes of Code Section 125, the regulations thereunder, and Internal Revenue Service Notice 2010-38, as such statutory provision, regulations or guidance may be amended or modified from time to time.

Solely for purposes of this Section 2.90 and Section 3.02(c), and only for the period beginning January 1, 2013, and ending on December 31, 2016, a "Spouse" will be deemed to include a Covered Participant's Same-Sex Domestic Partner, "marriage" will be deemed to include the establishment of a Same-Sex Domestic Partner relationship, "divorce" will be deemed to include the termination of a Same-Sex Domestic Partner relationship, and the term "Dependent" will be deemed to include a Same-Sex Domestic Partner and a Same-Sex Domestic Partner's Child; provided, however, that notwithstanding any other provision of the Plan, no Category of Coverage change under Section 3.02(c) involving a Same-Sex Domestic Partner or a Same-Sex

Domestic Partner's Child shall be made if such change would violate requirements of the Code or any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee, in their sole discretion, or would violate the requirements of any insurer under any HMO Option or Other Insured Arrangement.

2.91 **"Stepchild"** means any natural or adopted child of a Covered Participant's current Spouse or Covered Same-Sex Domestic Partner, and any natural or adopted child of a former Spouse or Same-Sex Domestic Partner of a Covered Participant living in the Covered Participant's home in a familial relationship if the natural parents of such child are both deceased.

2.92 **"Summary Plan Description"** means the summary plan description for the Plan.

ARTICLE III
PARTICIPATION

3.01 **Eligibility**. Subject to the specific eligibility restrictions provided for each Post-65 Retiree Coverage Option described in Article IV, Post-65 Retirees shall be eligible to participate in the Plan, and their eligible Dependents and eligible Dependents of certain Pre-65 Retirees may be eligible to be enrolled in the Plan, as follows:

(a) Post-65 Retirees. If he properly enrolls for coverage under Section 3.02, a Post-65 Retiree may be covered under the Plan as of the later of the date he (i) attains age 65, or (ii) becomes a Retiree.

(b) Dependents. A Covered Participant's eligible Dependent who is properly enrolled for coverage under Section 3.02 shall be covered on the earliest of (1) January 1 after the Annual Enrollment Period in which a Covered Participant elects to cover such Dependent; (2) the date a Post-65 Retiree's coverage becomes effective; or (3) the date coverage is provided under the Status Change Enrollment provisions of subsection 3.02(c).

(c) No Double Coverage. Notwithstanding the foregoing, no person is eligible to be covered as both a Participant and a Dependent, no person may be covered as a Dependent of more than one Covered Person, and no Employee may be covered as a Dependent.

(d) Reservation of Right to Amend and Terminate. The Committee reserves the right to amend or terminate the provisions for Post-65 Retiree participation and for enrollment of Dependents in accordance with Article XX.

3.02 **Enrollment**. Subject to the specific eligibility restrictions provided for each Post-65 Retiree Coverage Option described in Article IV, Post-65 Retirees shall be eligible to enroll in the Plan, and eligible Dependents of Covered Participants may be enrolled in the Plan, as follows:

(a) Post-65 Retirees. Each Post-65 Retiree who becomes eligible to become covered under subsection 3.01(a) shall properly enroll himself on or before the later of (i) the date he attains age 65, or (ii) the date he becomes a Retiree. Such Post-65 Retiree enrollment shall be effective on the first day of the month in which the Post-65 Retiree attains age 65 or becomes a Retiree, whichever is later. If the Post-65 Retiree attains age 65 or becomes a Retiree on the first day of the month, then such Post 65 Retiree enrollment shall be effective on the first day of the month immediately preceding the month in which the Post-65 Retiree attains age 65 or becomes a Retiree. A Post-65 Retiree who fails to

properly enroll pursuant to this subsection shall be covered pursuant to Sections 3.04 and 3.05.

A Post-65 Retiree who enrolls in the Plan, or a Pre-65 Retiree Plan Participant, may enroll his or her eligible Dependent in the Plan.

(b) Annual Enrollment Period. Subject to the provisions of Section 3.04 and Article IV, an eligible Post-65 Retiree, a Pre-65 Retiree Plan Participant, or a Qualified Beneficiary may elect or change a Post-65 Retiree Coverage Option or Category of Coverage during the Annual Enrollment Period. Such election shall be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year; provided, however, if such Post-65 Retiree, Pre-65 Retiree Plan Participant or Qualified Beneficiary makes no election or change during the Annual Enrollment Period, such Post-65 Retiree, Pre-65 Retiree or Qualified Beneficiary shall be deemed to have elected a Post-65 Retiree Coverage Option and Category of Coverage for the following Plan Year as described in Sections 3.04 and 3.05.

(c) Status Change Enrollment. If a Status Change occurs, a Post-65 Retiree or a Pre-65 Retiree Plan Participant may make a Category of Coverage change during the Status Change Enrollment Period provided under this subsection; provided, however, if required by Section 125 of the Code and the regulations, rulings and releases issued thereunder, such Category of Coverage change shall be consistent with the Status Change event. A Category of Coverage change is consistent with a Status Change event if, and only if, (1) the Status Change results in a Post-65 Retiree or Dependent gaining or losing eligibility for coverage under either the Plan or an accident or health plan of the Dependent's employer; and (2) the Category of Coverage change corresponds with such gain or loss of coverage.

Such Status Change Enrollment Period shall begin on the date of the Status Change event, and shall expire 31 days thereafter. Accordingly, to obtain or modify coverage under this subsection, the Post-65 Retiree shall properly modify his or her enrollment during such Status Change Enrollment Period. Any Category of Coverage change under this subsection shall be effective as of the date it is approved by the Plan.

(d) Judgment, Decree or Order. A Post-65 Retiree or a Pre-65 Retiree Plan Participant may make a Category of Coverage change upon entry of a court judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in Section 609 of ERISA) that requires Plan coverage for a Child.

(e) Entitlement to Medicare or Medicaid. A Post-65 Retiree or a Pre-65 Retiree Plan Participant may make a Category of Coverage change if a Covered Person becomes enrolled under Medicare Parts A, B or C, or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). Any such Category of Coverage change must be requested in the manner prescribed by the Plan Administrator within 31 days after the occurrence of the applicable event giving rise to the requested change and will become effective as of the date such change is approved by the Plan.

(f) Automatic Cost Change. If the cost of the Plan increases or decreases during a Plan Year, a Covered Participant is required to make corresponding change in his or her payments under the Plan. In such event, on a prospective basis, the Plan Administrator

shall automatically effectuate the increase or decrease in the Covered Participant's elective Covered Person Contributions.

(g) Significant Cost Change. Subject to the provisions of Section 3.04 and Article IV, a Covered Participant may make a Post-65 Retiree Coverage Option change if the cost of a Post-65 Retiree Coverage Option under the Plan significantly increases or decreases during a Plan Year. Any Post-65 Retiree Coverage Option change must correspond with such increase or decrease in cost. Changes that are permitted include commencing participation in a Post-65 Retiree Coverage Option that significantly decreases in cost, or, in the case of a Post-65 Retiree Coverage Option that significantly increases in cost, revoking an election for that Post-65 Retiree Coverage Option and, in lieu thereof, either receiving on a prospective basis coverage under another Post-65 Retiree Coverage Option providing similar coverage or dropping the Post-65 Retiree Coverage Option if no other Post-65 Retiree Coverage Option providing similar coverage is available. Any such Coverage Option change must be requested in the manner prescribed by the Plan Administrator within 31 days after the occurrence of the applicable event giving rise to the requested change and will become effective as of the date such change is approved by the Plan..

(h) Significant Coverage Change. Subject to the provisions of Section 3.04 and Article IV, a Covered Participant may make a Post-65 Retiree Coverage Option change:

(1) If the coverage under a Post-65 Retiree Coverage Option is significantly curtailed during a period of coverage, in which case the Covered Participant may revoke his or her election for coverage under such Post-65 Retiree Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Post-65 Retiree Coverage Option providing similar coverage;

(2) If the coverage under a Post-65 Retiree Coverage Option ceases during a period of coverage, in which case the Covered Participant may revoke his or her election for coverage under such Post-65 Retiree Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Post-65 Retiree Coverage Option providing similar coverage, or elect the No Coverage Option if no Post-65 Retiree Coverage Option providing similar coverage is available;

(3) If the Plan adds a new benefit or other coverage option or the terms of a benefit offered under the Plan are significantly improved during a period of coverage; or

(4) On account of and corresponding with a change made under another employer's plan if (i) the other cafeteria plan or qualified benefits plan permits participants to make an election that is consistent with the permitted election change rules under Section 125 of the Code and the regulations issued thereunder, or (ii) the Plan permits Covered Participants to make an election for a period of coverage that is different from the period of coverage under the other employer's cafeteria plan or qualified benefits plan.

Any such Coverage Option change must be requested in the manner prescribed by the Plan Administrator within 31 days after the occurrence of the applicable event giving rise to the requested change and will become effective as of the date such change is approved by the Plan..

(i) Election Changes involving the HMO Option or Other Insured Arrangements. Notwithstanding any other provision of the Plan, enrollment or a change in enrollment in

any HMO Option or Other Insured Arrangement shall be subject to any additional terms or conditions imposed by the insurer under such HMO Option or Other Insured Arrangement.

(j) Changes Involving Same-Sex Domestic Partners. Notwithstanding any provision of this Section 3.02, no Category of Coverage change, Coverage Option change, or change in Covered Person Contributions in respect of an event involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or of any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee in their sole discretion, or would violate the requirements of any insurer under any HMO Option or Other Insured Arrangement.

(k) Enrollment of Same-Sex Domestic Partners and Their Children. Effective January 1, 2017, no Post-65 Retiree or Pre-65 Retiree Plan Participant may enroll a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's child for coverage under the Plan.

3.03 Categories of Coverage. The Plan offers the following Categories of Coverage within each Post-65 Retiree Coverage Option:

(a) Post-65 Retiree-Only;

(b) Post-65 Retiree + Spouse;

(c) Post-65 Retiree + Child;

(d) Post-65 Retiree + Family;

(e) Spouse Only (only in case of Spouse of Pre-65 Retiree Plan Participant);

(f) Spouse + Child (only in case of Spouse and Child of Pre-65 Retiree Plan Participant);

(g) Spouse + Family (only in case of Spouse and Family of Pre-65 Retiree Plan Participant); and

(h) No Coverage.

Where applicable, Categories of Coverage include an eligible Same-Sex Domestic Partner and an eligible Child of a Same-Sex Domestic Partner.

3.04 Election of a Post-65 Retiree Coverage Option. A Post-65 Retiree or a Pre-65 Retiree Plan Participant may select a Post-65 Retiree Coverage Option as permitted in Article IV. Subject to the provisions of Article IV, such selection shall remain effective until properly changed during an Annual Enrollment Period, by reason of an event described in subsections 3.02(b)-(h), or by reason of the selection of the No Coverage Option at any time during the Plan Year. A Pre-65 Retiree Plan Participant who previously selected a Post-65 Retiree Plan Coverage Option for his or her Dependent and who subsequently becomes eligible for coverage under the Plan upon attaining age 65 may select only that Post-65 Retiree Coverage Option in which his or her Dependent is or has been enrolled or the No Coverage Option.

If a Pre-65 Retiree Plan Participant fails to properly enroll his or her eligible Dependent for coverage upon such Dependent attaining age 65, such Pre-65 Retiree Plan Participant shall be deemed to have selected the No Coverage Option. Such Pre-65 Retiree Plan Participant shall

have an opportunity to enroll his or her eligible Dependent for coverage during each Annual Enrollment Period thereafter.

If a Post-65 Retiree fails to properly enroll for coverage upon the later of reaching age 65 or becoming a Retiree, he shall be deemed to have selected the No Coverage Option. Such Post-65 Retiree shall have an opportunity to enroll for coverage during each Annual Enrollment Period thereafter.

Except as provided in the immediately following sentence, once a Post-65 Retiree or Pre-65 Retiree Plan Participant selects a Post-65 Retiree Coverage Option other than the No Coverage Option, he may not thereafter select a different Post-65 Retiree Coverage Option, other than the No Coverage Option. A Post-65 Retiree or Pre-65 Retiree Plan Participant may (i) select the No Coverage Option at any time during a Plan Year; (ii) during each Annual Enrollment Period or as otherwise permitted pursuant to subsections 3.02(b)-(h), make a change from the MAP Option to the MAP-Med Only Option, from the BSG Med Supp Option to the BSG Med Supp (Med Only) Option, or from the Medigap Supplement Option to the Medigap Med-Only Supplement Option; and (iii) during each Annual Enrollment Period or as otherwise permitted pursuant to subsections 3.02(b)-(h), enroll again in the Post-65 Retiree Coverage Option (other than the No Coverage Option) initially selected under the Plan, if such Post-65 Retiree or Pre-65 Retiree Plan Participant is currently enrolled in the No Coverage Option; provided, however, that enrollment in the MAP Option, the BSG Med Supp Option or the Medigap Supplement Option shall not be permitted if a Post-65 Retiree or Pre-65 Retiree Plan Participant has at any time enrolled in the MAP-Med Only Option, the BSG Med Supp (Med Only) Option or the Medigap Med-Only Supplement Option. For the avoidance of doubt, a change in Post-65 Retiree Coverage Option may not be made from the MAP-Med Only Option to the MAP Option, from the BSG Med Supp (Med Only) Option to the BSG Med Supp Option or from the Medigap Med-Only Supplement Option to the Medigap Supplement Option. Further, once a lifetime maximum has been attained by a Covered Person with respect to any Post-65 Retiree Coverage Option, no further coverage is available under the Plan. If a Post-65 Retiree or Pre-65 Retiree Plan Participant selects the No Coverage Option at any time during a Plan Year, he may not enroll again in the Post-65 Retiree Coverage Option he initially selected under the Plan except during the Annual Enrollment Period or as otherwise permitted pursuant to subsections 3.02(b)-(h).

3.05 Election of a Category of Coverage. Subject to the provisions of Section 3.04 and Article IV, a Post-65 Retiree or a Pre-65 Retiree Plan Participant may select or change a Category of Coverage during the enrollment periods set forth in Section 3.02. Any such selection shall remain effective until properly changed by the Post-65 Retiree or Pre-65 Retiree during an Annual Enrollment Period, or by reason of an event described in subsections 3.02(b)-(h).

ARTICLE IV
RETIREE COVERAGE

4.01 Participation in Particular Post-65 Retiree Coverage Options.

(a) Eligibility. Subject to the provisions of Article III, when a Retiree attains age 65 or becomes a Retiree after attaining age 65, or when his or her Dependent, or a Dependent of a Pre-65 Retiree Plan Participant, attains age 65, such person shall be eligible to participate in an Available Post-65 Retiree Coverage Option.

(b) Enrollment. Subject to the provisions of Article III, upon attaining age 65 or upon becoming a Retiree, a person described in Section 4.01(a) above may enroll or be

enrolled in an Available Post-65 Retiree Coverage Option or may elect or have elected for him the No Coverage Option. Provided, however, that effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child may be enrolled in coverage under the Plan.

(c) Contributions. The following provisions apply with respect to contributions toward the cost of coverage under the Plan:

(1) A Participant who participates in an Available Post-65 Retiree Coverage Option shall be required to contribute toward his or her coverage, and such Participant or a Pre-65 Retiree Plan Participant shall be required to contribute toward the coverage of his or her Dependents who are covered under the Plan, in an amount as determined from time to time by the Plan Administrator.

(2) If a Post-65 Retiree is eligible for Medicare coverage and is a member of a Covered Retiree Group for which a Defined Dollar Subsidy or other premium subsidy is made available, as indicated by Schedule 1 attached hereto, such Post-65 Retiree and his or her Spouse or Same-Sex Domestic Partner, if the Spouse or Same-Sex Domestic Partner is over age 65 and a Covered Person, shall be credited with an annual Defined Dollar Subsidy or other premium subsidy, as applicable, toward the cost of coverage in the amount indicated by Schedule 1. If a Pre-65 Retiree Plan Participant is a member of a Covered Retiree Group for which a Defined Dollar Subsidy or other premium subsidy is made available, as indicated by Schedule 1 attached hereto, his or her Spouse or Same-Sex Domestic Partner, if over age 65 and a Covered Person, shall be credited with an annual Defined Dollar Subsidy or other premium subsidy, as applicable, toward the cost of coverage in the amount indicated by Schedule 1. The Covered Participant shall remain responsible for the cost of coverage to the extent such cost exceeds the Defined Dollar Subsidy or other premium subsidy.

(3) The Defined Dollar Subsidy for an eligible Post-65 Retiree is an annual amount to be applied toward the cost of coverage under the Plan that is equal to the product of (i) a dollar value, as specified in Schedule 1 attached hereto, multiplied by (ii) the Post-65 Retiree's Years of Service. The Defined Dollar Subsidy for an eligible Covered Participant's Spouse or Same-Sex Domestic Partner who is a Covered Person is an annual amount to be applied toward the cost of coverage for the Spouse or Same-Sex Domestic Partner under the Plan that is equal to the product of (i) a dollar value, as specified in Schedule 1 attached hereto, multiplied by (ii) the Covered Participant's Years of Service. For purposes of this Section 4.01(c)(3) only, "Years of Service" equals the total number of Years of Service at retirement, rounded up to the nearest whole number, earned by the Post-65 Retiree or Pre-65 Retiree Plan Participant for purposes of benefit accrual (including all service prior to a distribution that causes any prior service to be disregarded) under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan. Notwithstanding the foregoing, for purposes of the Special Provisions Applicable to Certain Outsourced and Severed Employees described in Section 4.03, "Years of Service" for purposes of this Section 4.01(c)(3) shall mean "Years of Service" as defined in subsection 4.03(d).

(4) If a Covered Participant dies prior to his or her eligible Spouse or Same-Sex Domestic Partner, the surviving Spouse or Same-Sex Domestic Partner, if age 65 or older, shall be credited with a Defined Dollar Subsidy in the same amount as a Post-65 Retiree who is a member of the same Covered Retiree Group as the Covered Participant.

(5) If a Post-65 Retiree is a member of a Covered Retiree Group for which a Medicare Part B reimbursement, a Medicare Part D reimbursement, or any other reimbursement is made available, as indicated by Schedule 1 attached hereto, the Post-65 Retiree shall be credited with such reimbursement in the amount indicated by Schedule 1.

(6) Contributions shall also be governed by Article VIII. The Committee reserves the right to modify these contribution provisions from time to time.

(d) Rehires. A Retiree who is rehired by an Employer and subsequently retires shall be considered a member of the Covered Retiree Group applicable to such Retiree as of the date of his or her latest retirement.

4.02 Special Provisions Applicable to 2002 NiSource Organization Restructuring. From August 28, 2002, through December 31, 2002, certain Employees were notified of their involuntary separation under the 2002 NiSource Inc. Organization Restructuring (the "2002 Restructuring"). The purpose of this Section is to specify the special provisions that apply to Employees who were eligible for and elected the Defined Dollar Subsidy for retiree medical coverage offered pursuant to the 2002 Restructuring.

(a) Retiree Medical Benefits Offered in Connection with the 2002 NiSource Inc. Organization Restructuring.

An Employee who:

(1) Was notified of his or her involuntary separation from an Employer under the 2002 Restructuring between August 28, 2002 and December 31, 2002;

(2) Elected salary continuation as his or her severance benefit option and, at the end of the salary continuation period, was age 50 to 54 with 10 Years of Service;

(3) Properly executed the release attached to his or her Severance Agreement in accordance with the procedures set forth in that Severance Agreement, or if appropriate, any subsequently tendered release from the Company or an affiliate thereof; and

(4) Was eligible for and elected the Defined Dollar Subsidy offered in connection with the 2002 Restructuring,

shall be eligible, subject to the other provisions of Article IV, including without limitation Section 4.01(a), for retiree medical coverage under the MAP-Med Only Option, the MAP Option or the Medicare Supplement Option and shall be credited with an annual Defined Dollar Subsidy toward the cost of such coverage. The Post-65 Retiree or Pre-65 Retiree Plan Participant shall remain responsible for the annual cost of coverage to the extent such cost exceeds the Defined Dollar Subsidy equal to the applicable amount set forth in subsection 4.02(b).

(b) Medicare-Eligible Defined Dollar Subsidy. On and after the date the former Employee becomes eligible for Medicare coverage, the annual Defined Dollar Subsidy shall equal $60 times Years of Service towards coverage for the former Employee, and $40 times Years of Service towards coverage for his or her Spouse.

(c) Years of Service. For purposes of this Section only, "Years of Service" equals the total number of Years of Service at retirement, rounded up to the nearest whole number, earned by the Post-65 Retiree or Pre-65 Retiree Plan Participant for purposes of benefit accrual (including all service prior to a distribution that causes any prior service to be disregarded) under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan.

4.03 Special Provisions Applicable to Certain Outsourced and Severed Employees. Notwithstanding any provision of the Plan to the contrary, but subject to the particular eligibility provisions of each section of this Article IV, any Participant who (i) was notified in writing on June 21, 2005, or any following date up to and including December 31, 2005, that his or her employment was outsourced to International Business Machines Corporation (the "IBM Outsourcing"), (ii) received an initial Severance Letter Agreement dated on June 21, 2005, or any following date up to and including December 31, 2005, from the Company in connection with the IBM Outsourcing, (iii) elected by January 10, 2006 to be part of the termination from service window offered to employees eligible for the NiSource Inc. Executive Severance Policy, or (iv) was otherwise terminated from employment in connection with the 2005/2006 corporate restructuring on or before March 31, 2006, as reflected in his termination letter, shall be considered a Retiree and, subject to the other provisions of Article IV, including without limitation Section 4.01(a), shall be eligible for retiree medical coverage under the MAP-Med Only Option, the MAP Option or the Medicare Supplement Option as follows:

(a) Each Participant who was age 50 to 54 with at least 10 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree upon reaching age 55;

(b) Each Participant who was age 55 or over with 5 to 9 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree as of the date that such individual would have completed 10 Years of Service had he continued to be employed by the Company or a Related Employer but for the IBM Outsourcing or related severance; and

(c) Each Participant who was age 50 or over with 5 to 9 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree as of the date that such individual reaches age 55 and would have completed 10 Years of Service had he continued to be employed by the Company or a Related Employer but for the IBM Outsourcing or related severance.

(d) For purposes of this Section 4.03 and Section 4.01(c)(3), "Years of Service" equals the number of Years of Service earned by a former Employee towards eligibility for an early retirement pension under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee participated, as calculated under the terms of each applicable defined benefit pension plan; provided, however, that Years of Service shall not include any pension service time added as a result of the IBM Outsourcing or severance in connection with the IBM Outsourcing.

4.04 MAP Option. The terms and conditions of coverage under the MAP Option are as follows:

(a) MAP Deductible.

(1) Medicare Part A. All services considered under Medicare Part A are subject to the payment of the MAP Deductible.

(2) Medicare Part B. All services considered under Medicare Part B are subject to the payment of the MAP Deductible.

(b) Lifetime Maximum. The total maximum benefit payable under the MAP Option and the MAP-Med Only Option, separately and collectively, with respect to each Covered Person during such person's lifetime shall not exceed $50,000.

(c) Benefits. The MAP Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist visits), up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

(2) Preventive and Wellness Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible, for the following services:

(A) Routine gynecological exam;

(B) Routine annual mammogram;

(C) Routine annual Pap smear test;

(D) Routine flexible sigmoidoscopy; and

(E) Routine prostate cancer screening;

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays, allergy tests and laboratory tests, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

(4) Outpatient Services. For surgery, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

(5) Emergency Services. For emergency room services, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare deductible and the MAP Deductible.

(6) Hospital Services.

(A) Inpatient days covered by Medicare (including the inpatient deductible for inpatient days covered by Medicare) are not covered or payable under the Plan. Without limiting the generality of the foregoing, inpatient

facility charges and skilled nursing facility charges covered by Medicare are not covered by the Plan.

(B) For semi-private room and board charges, surgery services and x-ray and laboratory services, after Covered Person's payment of the MAP Deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(7) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%. The Plan shall provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when the Covered Person obtains prior approval and is required to travel more than 100 miles from his or her residence to reach the Hospital where the covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Hospital and lodging for the patient and one companion. Benefits for lodging are limited to $75.00 per day. Travel expenses and lodging expenses, on a combined basis, are limited to $20,000. To obtain reimbursement, the Covered Person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator.

(8) Prescription Drug Coverage. The MAP Option shall provide prescription drug coverage. A Post-65 Retiree who enrolls in Medicare Part D shall automatically be deemed to have elected the MAP-Med Only Option. A Post-65 Retiree who elects, or is deemed to have elected, the MAP-Med Only Option shall not be eligible to participate in the MAP Option at a later date. Prescription drug coverage under the MAP Option shall be provided in accordance with the provisions of Article IX.

(9) Mental Health Services.

(A) *Inpatient Treatment - Facility.* After Covered Person's payment of the MAP Deductible, 85% of charges not covered by Medicare.

(B) *Inpatient Treatment - Professional.* After Covered Person's payment of the MAP Deductible, remaining 20% of charges not covered by Medicare.

(C) *Outpatient Treatment.* After Covered Person's payment of the MAP Deductible, 85% of Medicare-approved charges not paid by Medicare.

(10) Substance Use Disorder Services.

(A) *Inpatient Treatment - Facility.* After Covered Person's payment of the MAP Deductible, 85% of charges not covered by Medicare.

(B) *Inpatient Treatment - Professional.* After Covered Person's payment of the MAP Deductible, remaining 20% of charges not covered by Medicare.

(C) *Outpatient Treatment.* After Covered Person's payment of the MAP Deductible, 85% of Medicare-approved charges not paid by Medicare.

(11) Other Services. For durable medical equipment, vision benefits (one routine vision exam and refraction per year) and hearing benefits (diagnostic hearing exams only), up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

4.05 MAP-Med Only Option. The terms and conditions of coverage under the MAP-Med Only Option are as follows:

(a) MAP Deductible.

(1) Medicare Part A. All services considered under Medicare Part A are subject to the payment of the MAP Deductible.

(2) Medicare Part B. All services considered under Medicare Part B are subject to the payment of the MAP Deductible.

(b) Lifetime Maximum. The total maximum benefit payable under the MAP Option and the MAP-Med Only Option, separately and collectively, with respect to each Covered Person during such person's lifetime shall not exceed $50,000.

(c) Benefits. The MAP Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist visits) and surgical/hospital visits, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

(2) Preventive and Wellness Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible, for the following services:

(A) Routine gynecological exam;

(B) Routine annual mammogram;

(C) Routine annual Pap smear test;

(D) Routine flexible sigmoidoscopy; and

(E) Routine prostate cancer screening;

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays, allergy tests and laboratory tests, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

(4) Outpatient Services. For surgery, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

(5) Emergency Services. For emergency room services, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare deductible and the MAP Deductible.

(6) Hospital Services.

(A) Inpatient days covered by Medicare (including the inpatient deductible for inpatient days covered by Medicare) are not covered or payable under the Plan. Without limiting the generality of the foregoing, inpatient facility charges and skilled nursing facility charges covered by Medicare are not covered by the Plan.

(B) For semi-private room and board charges, surgery services and x-ray and laboratory services, after Covered Person's payment of the MAP Deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(7) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%. The Plan shall provide assistance with reasonable and necessary travel expenses as determined by the Plan Administrator when the Covered Person obtains prior approval and is required to travel more than 100 miles from his or her residence to reach the Hospital where the covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Hospital and lodging for the patient and one companion. Benefits for lodging are limited to $75.00 per day. Travel expenses and lodging expenses, on a combined basis, are limited to $20,000. To obtain reimbursement, the Covered Person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Plan Administrator.

(8) Prescription Drug Coverage. The MAP-Med Only Option does not provide prescription drug coverage. A Post-65 Retiree who enrolls in Medicare Part D shall automatically be deemed to have elected the MAP-Med Only Option. A Post-65 Retiree who elects, or is deemed to have elected, the MAP-Med Only Option shall not be eligible to participate in the MAP Option at a later date.

(9) Mental Health Services.

(A) *Inpatient Treatment - Facility.* After Covered Person's payment of the MAP Deductible, 85% of charges not covered by Medicare.

(B) *Inpatient Treatment - Professional.* After Covered Person's payment of the MAP Deductible, remaining 20% of charges not covered by Medicare.

(C) *Outpatient Treatment.* After Covered Person's payment of the MAP Deductible, 85% of Medicare-approved charges not paid by Medicare.

(10) Substance Use Disorder Services.

(A) *Inpatient Treatment - Facility.* After Covered Person's payment of the MAP Deductible, 85% of charges not covered by Medicare.

(B) *Inpatient Treatment - Professional.* After Covered Person's payment of the MAP Deductible, remaining 20% of charges not covered by Medicare.

(C) *Outpatient Treatment.* After Covered Person's payment of the MAP Deductible, 85% of Medicare-approved charges not paid by Medicare.

(11) Other Services. For durable medical equipment, vision benefits (one routine vision exam and refraction per year) and hearing benefits (diagnostic hearing exams only), up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible and the MAP Deductible.

4.06 Medicare Supplement Option. The terms and conditions of coverage under the Medicare Supplement Option are as follows:

(a) Payment of Medicare Deductibles.

(1) Medicare Part A. The Plan pays the Medicare Part A deductible, except for lifetime reserve days.

(2) Medicare Part B. The Plan pays one hundred percent of the annual Medicare Part B deductible.

(b) Benefits. The Medicare Supplement Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist visits), Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(2) Preventive and Wellness Services. Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80% for the following services:

(A) Flu, pneumonia and hepatitis B shots;

(B) Routine gynecological exam (once every 24 months);

(C) Routine annual mammogram;

(D) Routine Pap smear test (once every 24 months);

(E) Routine flexible sigmoidoscopy (once every 48 months); and

(F) Routine prostate cancer screening (once every 12 months);

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays and allergy tests, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%. Laboratory services are not covered.

(4) Outpatient Services. For surgery, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(5) Emergency Services. For emergency room services, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(6) Hospital Services.

(A) For semi-private room and board charges, Medicare Part A deductible and 100% of charges not paid by Medicare from days 61-90 of confinement.

(B) For x-ray and laboratory services, payment of the Medicare Part A deductible.

(7) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%. Meals are not covered.

(8) 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.

(9) Skilled Nursing Facility. 12.5% of the Medicare inpatient hospital deductible for room and board charges from day 21 to day 100 for a skilled nursing facility confinement in a facility approved by Medicare.

(10) Prescription Drug Coverage. The Medicare Supplement Option does not provide prescription drug coverage.

(11) Mental Health Services.

(A) *Inpatient Treatment.* After Plan payment of Medicare deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(B) *Outpatient Treatment.* After Plan payment of Medicare deductible, 80% of Medicare-approved charges not paid by Medicare.

(12) Substance Use Disorder Services.

(A) *Inpatient Treatment.* After Plan payment of Medicare deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(B) *Detoxification.* After Plan payment of Medicare deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(C) *Outpatient Treatment.* After Plan payment of Medicare deductible, 80% of Medicare-approved charges not paid by Medicare.

(13) Other Services. For durable medical equipment, vision benefits (diagnostic vision exams only) and hearing benefits (diagnostic hearing exams only),

Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

4.07 NIPSCO Medicare Supplement Option. The terms and conditions of coverage under the NIPSCO Medicare Supplement Option are as follows:

(a) Payment of Medicare Deductibles.

(1) Medicare Part A. The Plan pays the Medicare Part A deductible, except for lifetime reserve days.

(2) Medicare Part B. The Plan pays one hundred percent of the annual Medicare Part B deductible.

(b) Annual Maximum. The benefit payable under the NIPSCO Medicare Supplement Option shall not exceed $450,000 per Covered Person per Plan Year. Provided, however, when the benefit maximum is reached during a Plan Year due to expenses incurred for human organ and tissue transplants, an additional benefit not to exceed $50,000 per Covered Person per Plan Year may be applied toward expenses incurred for human organ and tissue transplants.

(c) Benefits. The Medicare Supplement Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist visits) and surgical/hospital visits, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(2) Preventive and Wellness Services. Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80% for the following services:

(A) Flu, pneumonia and hepatitis B shots;

(B) Routine gynecological exam (once every 24 months);

(C) Routine annual mammogram;

(D) Routine Pap smear test (once every 24 months);

(E) Routine flexible sigmoidoscopy (once every 48 months); and

(F) Routine prostate cancer screening (once every 12 months);

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays, allergy tests and laboratory tests, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(4) Outpatient Services. For surgery, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(5) Emergency Services. For emergency room services, Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

(6) Hospital Services.

(A) For semi-private room and board charges, Medicare Part A deductible and 25% of the Medicare-eligible charges not paid by Medicare from days 61-90 of confinement.

(B) For x-ray and laboratory services, payment of the Medicare Part A deductible.

(7) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%. Meals are not covered.

(8) 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.

(9) Prescription Drug Coverage. There is a 100% co-pay requirement for all prescription drugs. A Covered Participant's medical identification card may be used to obtain discounts at participating pharmacies.

(10) Mental Health Services.

(A) *Inpatient Treatment.* After Plan payment of Medicare deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(B) *Outpatient Treatment.* After Plan payment of Medicare deductible, 80% of Medicare-approved charges not paid by Medicare.

(11) Substance Use Disorder Services.

(A) *Inpatient Treatment.* After Plan payment of Medicare deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(B) *Detoxification.* After Plan payment of Medicare deductible, 80% of charges not covered by Medicare due to Medicare day maximum being exhausted.

(C) *Outpatient Treatment.* After Plan payment of Medicare deductible, 80% of Medicare-approved charges not paid by Medicare.

(12) Other Services. For durable medical equipment, vision benefits (diagnostic vision exams only) and hearing benefits (diagnostic hearing exams only), Medicare deductible and up to 20% of Medicare-approved charges for which Medicare pays 80%.

4.08 Medigap Supplement Option. The terms and conditions of coverage under the Medigap Supplement Option are as follows:

(a) Medical Benefits. Medical benefits under the Medigap Supplement Option are offered through an Other Insured Arrangement Option.

(b) Prescription Drug Coverage. Prescription drug coverage under the Medigap Supplement Option shall be provided in accordance with the provisions of Article IX, but shall be limited to an annual maximum of $5,000 per Covered Person per Plan Year.

4.09 Medigap Med-Only Supplement Option. The terms and conditions of coverage under the Medigap Med-Only Supplement Option are as follows:

(a) Medical Benefits. Medical benefits under the Medigap Supplement Option are offered through an Other Insured Arrangement Option.

(b) Prescription Drug Coverage. No prescription drug coverage is provided under the Medigap Med-Only Supplement Option. A Post-65 Retiree who enrolls in Medicare Part and who elects Medigap coverage shall automatically be deemed to have elected the Medigap Med-Only Supplement Option. A Post-65 Retiree who elects, or is deemed to have elected, the Medigap Med-Only Supplement Option shall not be eligible to participate in the Medigap Supplement Option at a later date.

4.10 BSG Med Supp Multi-Union Option. The terms and conditions of coverage under the BSG Med Supp Multi-Union Option are as follows:

(a) Lifetime Maximum. The total maximum benefit payable under the BSG Med Supp Multi-Union Option with respect to each Covered Person during such person's lifetime shall not exceed $2,000,000.

(b) Benefits. The BSG Med Supp Multi-Union Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist) and surgical/hospital visits, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible.

(2) Preventive and Wellness Services. Full coverage, for the following services:

(A) One routine fecal-occult blood test every year;

(B) One routine flexible sigmoidoscopy every four years;

(C) One routine colonoscopy every two years for a Covered Person at high-risk for cancer;

(D) Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare;

(E) Routine prostate cancer screening, including one (PSA) test and one digital rectal exam, per calendar year;

(F) One routine gynecological exam every two years;

(G) One routine gynecological exam per calendar year for a Covered Person at high risk for cancer, if covered by Medicare;

(H) One routine mammogram per calendar year; and

(I) One routine Pap smear test per calendar year (exam not covered every year unless covered by Medicare for Covered Person at high risk for cancer).

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays, allergy tests and laboratory tests, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare Part B deductible.

(4) Outpatient Services. For surgery, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare deductible.

(5) Emergency Services. For emergency room services, up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare deductible.

(6) Hospital Services. (i) for the first 60 days of the Medicare benefit period, 100% of the Medicare deductible; (ii) for day 61 through day 90 of the Medicare benefit period, 100% of the remaining Medicare-approved charges not paid by Medicare; (iii) 100% coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days; and (iv) 90% coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(7) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%.

(8) Mental Health Services.

(A) *Inpatient Treatment.* For the first 60 days of confinement in a Hospital, 100% of the inpatient hospital deductible of Medicare. For day 61 through day 90 of inpatient hospital confinement, 100% of the Medicare coinsurance. For day 91 through 150 of inpatient hospital confinement, coinsurance per day. For inpatient hospital confinement after 150 days, 90% of covered services up to 365 additional hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional days per Covered Person's lifetime are a combination of days in a general or mental Hospital. Benefits for the additional 365 days that are covered once Medicare benefits are exhausted will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(B) *Outpatient Treatment.* Fifty percent of Medicare-approved charges for which Medicare pays 50%.

(9) Substance Use Disorder Services.

(A) *Inpatient Treatment.* For the first 60 days of confinement in a Hospital, 100% of the inpatient hospital deductible of Medicare. For day 61 through day 90 of inpatient hospital confinement, 100% of the Medicare coinsurance. For day 91 through 150 of inpatient hospital confinement, coinsurance per day. For inpatient hospital confinement after 150 days, 90% of covered services up to 365 additional hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional days per Covered Person's lifetime are a combination of days in a general or mental Hospital. Benefits for the additional 365 days that are covered once Medicare benefits are exhausted will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.).

(B) *Detoxification.* For the first 60 days of confinement in a Hospital, 100% of the inpatient hospital deductible of Medicare. For day 61 through day 90 of inpatient hospital confinement, 100% of the Medicare coinsurance. For day 91 through 150 of inpatient hospital confinement, coinsurance per day. For inpatient hospital confinement after 150 days, 90% of covered services up to 365 additional hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional days per Covered Person's lifetime are a combination of days in a general or mental Hospital. Benefits for the additional 365 days that are covered once Medicare benefits are exhausted will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.).

(C) *Outpatient Treatment.* Fifty percent of Medicare-approved charges for which Medicare pays 50%.

(10) Skilled Nursing Facility. For a skilled nursing facility, 100% of Medicare coinsurance for days 21 through 100. No benefits are provided for services rendered after 100 days of continuous confinement.

(11) Other Services. For durable medical equipment, vision benefits (diagnostic vision exams only) and hearing benefits (diagnostic hearing exams only), up to 20% of Medicare-approved charges for which Medicare pays 80%, after Covered Person's payment of the Medicare deductible.

(12) Certain Charges Excluded. Private duty nursing charges covered by Medicare are not covered under the Plan. In addition, except with respect to services obtained in connection with true medical emergencies, no benefits shall be provided unless services are obtained from a Contracted Provider.

4.11 BSG Med Supp (Med Only) Option. The terms and conditions of coverage under the BSG Med Supp (Med Only) Option are as follows:

(a) Lifetime Maximum. The total maximum benefit payable under the BSG Med Supp (Med Only) Option and the BSG Med Supp Option, separately and collectively, with respect to each Covered Person during such person's lifetime shall not exceed $2,000,000.

(b) Benefits. The BSG Med Supp Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist) and surgical/hospital visits, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(2) Preventive and Wellness Services. One hundred percent of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80% for the following services:

(A) One routine fecal-occult blood test every year;

(B) One routine flexible sigmoidoscopy every four years;

(C) One routine colonoscopy every two years for a Covered Person at high-risk for cancer;

(D) Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare;

(E) Routine prostate cancer screening, including one (PSA) test and one digital rectal exam, per calendar year;

(F) One routine gynecological exam every two years;

(G) One routine gynecological exam per calendar year for a Covered Person at high risk for cancer, if covered by Medicare;

(H) One routine mammogram per calendar year; and

(I) One routine Pap smear test per calendar year (exam not covered every year unless covered by Medicare for Covered Person at high risk for cancer).

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays, allergy tests and laboratory tests, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(4) Outpatient Services. For surgery, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(5) Emergency Services. For emergency room services, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(6) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%.

(7) Hospital Services. (i) for the first 60 days of the Medicare benefit period, 100% of the Medicare deductible; (ii) for day 61 through day 90 of the Medicare benefit period, 100% of the remaining Medicare-approved charges not paid by Medicare; (iii) 100% coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days; and (iv) 100% coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(8) Prescription Drugs. No prescription drug coverage is provided under the BSG Med Supp (Med Only) Option. A Post-65 Retiree who enrolls in Medicare Part D shall automatically be deemed to have elected the BSG Med Only Option. A Post-65 Retiree who elects, or is deemed to have elected, the BSG Med Supp (Med Only) Option shall not be eligible to participate in the BSG Med Supp Option at a later date.

(9) Mental Health Services.

(A) *Inpatient Treatment.* For the first 60 days of the Medicare benefit period, 100% of the Medicare deductible. For day 61 through day 90 of the Medicare benefit period, 100% of Medicare-approved charges for which Medicare pays 80%. One hundred percent coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days. One hundred percent coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(B) *Outpatient Treatment.*

(i) *Biologically based mental conditions.* With respect to biologically based mental conditions (treatment for rape-related mental or emotional disorders is covered to the same extent as biologically-based conditions), when covered by Medicare, 100% of the Medicare deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges (with no visit maximum). When visits are not covered by Medicare, 100% coverage of services (with no visit maximum) at rate negotiated between the exclusive provider organization and the Contracted Provider.

(ii) *Non-biologically based mental conditions.* (Includes drug addiction and alcoholism). When covered by Medicare, 100% of

the Medicare Part B deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges (with no visit maximum).

(10) Substance Abuse.

(A) *Inpatient Treatment.* For the first 60 days of the Medicare benefit period, 100% of the inpatient hospital deductible of Medicare. For day 61 through day 90 of the Medicare benefit period, coverage of coinsurance not paid by Medicare for Medicare-approved charges. One hundred percent coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days. One hundred percent coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

For non-biologically based mental conditions (includes drug addiction and alcoholism) involving inpatient admission in a general Hospital or mental Hospital, (i) for the first 60 days of the Medicare benefit period, 100% of the Medicare deductible; (ii) for day 61 through day 90 of the Medicare benefit period, coverage of coinsurance not paid by Medicare for Medicare-approved charges; (iii) 100% coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days; and (iv) 100% coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(B) *Outpatient Treatment.* For non-biologically based mental conditions (includes drug addiction and alcoholism), when covered by Medicare, 100% of the Medicare Part B deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges. When not covered by Medicare, 100% coverage of up to 24 visits per calendar year at the rate negotiated between the exclusive provider organization and the Contracted Provider.

(11) Skilled Nursing Facility. For a skilled nursing facility participating with Medicare, 100% of Medicare coinsurance for days 21 through 100, then $10 daily for days 101 through 365. For a skilled nursing facility not participating with Medicare, $8 daily. Coverage is limited to a combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

(12) Other Services. For durable medical equipment, vision benefits (diagnostic vision exams only) and hearing benefits (diagnostic hearing exams only), 100%

of the Medicare Part B deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges.

(13) Certain Charges Excluded. Private duty nursing charges covered by Medicare are not covered under the Plan. In addition, except with respect to services obtained in connection with true medical emergencies, no benefits shall be provided unless services are obtained from a Contracted Provider.

4.12 BSG Med Supp Option. The terms and conditions of coverage under the BSG Med Supp Option are as follows:

(a) Lifetime Maximum. The total maximum benefit payable under the BSG Med Supp (Med Only) Option and the BSG Med Supp Option, separately and collectively, with respect to each Covered Person during such person's lifetime shall not exceed $2,000,000.

(b) Benefits. The BSG Med Supp Option provides the following benefits:

(1) Physician Services. For office visits (primary care and specialist) and surgical/hospital visits, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(2) Preventive and Wellness Services. One hundred percent of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80% for the following services:

(A) One routine fecal-occult blood test every year;

(B) One routine flexible sigmoidoscopy every four years;

(C) One routine colonoscopy every two years for a Covered Person at high-risk for cancer;

(D) Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare;

(E) Routine prostate cancer screening, including one (PSA) test and one digital rectal exam, per calendar year;

(F) One routine gynecological exam every two years;

(G) One routine gynecological exam per calendar year for a Covered Person at high risk for cancer, if covered by Medicare;

(H) One routine mammogram per calendar year; and

(I) One routine Pap smear test per calendar year (exam not covered every year unless covered by Medicare for Covered Person at high risk for cancer).

Routine physical exams are not covered under this Option.

(3) Diagnostic Services. For x-rays, allergy tests and laboratory tests, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(4) Outpatient Services. For surgery, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(5) Emergency Services. For emergency room services, 100% of the Medicare deductible, plus 20% of Medicare-approved charges for which Medicare pays 80%.

(6) Transplant Services. Up to 20% of Medicare-approved charges for which Medicare pays 80%.

(7) Hospital Services. (i) for the first 60 days of the Medicare benefit period, 100% of the Medicare deductible; (ii) for day 61 through day 90 of the Medicare benefit period, 100% of the remaining Medicare-approved charges not paid by Medicare; (iii) 100% coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days; and (iv) 100% coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(8) Prescription Drugs. The BSG Med Supp Option shall provide prescription drug coverage. No prescription drug coverage is provided under the BSG Med Supp (Med Only) Option. A Post-65 Retiree who enrolls in Medicare Part D shall automatically be deemed to have elected the BSG Med Only Option. A Post-65 Retiree who elects, or is deemed to have elected, the BSG Med Supp (Med Only) Option shall not be eligible to participate in the BSG Med Supp Option at a later date. Prescription drug coverage under the BSG Med Supp Option shall be provided in accordance with the provisions of Article IX.

(9) Mental Health Services.

(A) *Inpatient Treatment.* For the first 60 days of the Medicare benefit period, 100% of the Medicare deductible. For day 61 through day 90 of the Medicare benefit period, 20% of Medicare-approved charges for which Medicare pays 80%. One hundred percent coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days. One hundred percent coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(B) *Outpatient Treatment.*

(i) *Biologically based mental conditions.* With respect to biologically based mental conditions (treatment for rape-related mental or emotional disorders is covered to the same extent as biologically-based conditions), when covered by Medicare, 100% of the Medicare deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges (with no visit maximum). When visits are not covered by Medicare, 100% coverage of services (with no visit maximum) at rate negotiated between the exclusive provider organization and the Contracted Provider.

(ii) *Non-biologically based mental conditions.* (Includes drug addiction and alcoholism). When covered by Medicare, 100% of the Medicare Part B deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges (with no visit maximum).

(10) Substance Abuse.

(A) *Inpatient Treatment.* For the first 60 days of the Medicare benefit period, 100% of the inpatient hospital deductible of Medicare. For day 61 through day 90 of the Medicare benefit period, coverage of coinsurance not paid by Medicare for Medicare-approved charges. One hundred percent coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days. One hundred percent coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

For non-biologically based mental conditions (includes drug addiction and alcoholism) involving inpatient admission in a general Hospital or mental Hospital, (i) for the first 60 days of the Medicare benefit period, 100% of the Medicare deductible; (ii) for day 61 through day 90 of the Medicare benefit period, coverage of coinsurance not paid by Medicare for Medicare-approved charges; (iii) 100% coverage for the lifetime reserve day coinsurance for the 60 lifetime reserve days; and (iv) 100% coverage of up to 365 additional Hospital days in a Covered Person's lifetime when Medicare benefits are exhausted. (The 365 additional Hospital days per Covered Person's lifetime are a combination of days in a general or mental Hospital, including inpatient treatment for substance use disorders. Benefits for such additional days will be paid at the rate negotiated between the exclusive provider organization and the Contracted Provider.)

(B) *Outpatient Treatment.* For non-biologically based mental conditions (includes drug addiction and alcoholism), when covered by Medicare,

100% of the Medicare Part B deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges. When not covered by Medicare, 100% coverage of up to 24 visits per calendar year at the rate negotiated between the exclusive provider organization and the Contracted Provider.

(11) Skilled Nursing Facility. For a skilled nursing facility participating with Medicare, 100% of Medicare coinsurance for days 21 through 100, then $10 daily for days 101 through 365. For a skilled nursing facility not participating with Medicare, $8 daily. Coverage is limited to a combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

(12) Other Services. For durable medical equipment, vision benefits (diagnostic vision exams only) and hearing benefits (diagnostic hearing exams only), 100% of the Medicare Part B deductible, plus coverage of coinsurance not paid by Medicare for Medicare-approved charges.

(13) Certain Charges Excluded. Private duty nursing charges covered by Medicare are not covered under the Plan. In addition, except with respect to services obtained in connection with true medical emergencies, no benefits shall be provided unless services are obtained from a Contracted Provider.

4.13 Special Provisions Applicable to Post-65 Retirees Who Are Former Represented Employees.

(a) Eligibility. Notwithstanding any other provision in Article IV, Post-65 Retirees who retired from employment with an Employer as Represented Employees, and their Dependents, shall be eligible for coverage under this Article IV only to the extent provided by the respective collective bargaining agreements applicable to such Post-65 Retirees as former Represented Employees.

(b) Contributions. Notwithstanding any other provision in Article IV, Post-65 Retirees who retired from employment with an Employer as Represented Employees shall be required to contribute to coverage under this Article IV as provided by the respective collective bargaining agreements applicable to such Post-65 Retirees as former Represented Employees.

ARTICLE V
HMO OPTION

The Plan may make an HMO Option available. The terms and conditions applicable to such Option shall be contained in the certificate of coverage, the group insurance policy, and other applicable governing documents, which are incorporated herein by reference.

ARTICLE VI
OTHER INSURED ARRANGEMENT OPTION

The Plan may make an Other Insured Arrangement Option available. The terms and conditions applicable to such Option shall be contained in applicable certificates of coverage, any applicable group insurance policy, and other applicable governing documents, which are incorporated herein by reference.

ARTICLE VII
PARTICIPANT PAYMENTS AND LIMITS

7.01 Deductible. The 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.

7.02 Co-Insurance. After Covered Expenses incurred in a calendar year equal the Deductible amount, the Plan will pay the Covered Percentage of Covered Expenses incurred in that calendar year. The Covered Participant shall be responsible for any applicable Co-Insurance. Applicable Covered Percentages and Co-Insurance are set forth in Article IV.

7.03 Co-Payments. A Co-Payment applies to certain Covered Expenses. Applicable Co-Payments are set forth in the Plan.

7.04 Out-of-Pocket Expense Limitation. The out-of-pocket expenses of a Covered Person for Co-Insurance during any Plan Year shall be limited to the amount set forth in Articles IV and IX. Once the applicable Out-of-Pocket Expense Limitation has been reached, 100% of any remaining Covered Expenses for such person or family shall be paid during the balance of that Plan Year. Any out-of-pocket expenses applied to the In-Network Out-of-Pocket Expense Limitation shall also apply to the Out-of-Network Out-of-Pocket Expense Limitation, and any out-of-pocket expenses applied to the Out-of-Network Out-of-Pocket Expense Limitation shall also apply to the In-Network Out-of-Pocket Expense Limitation.

7.05 Maximum Benefits. Lifetime and annual maximum limits on benefits payable under the Plan are set forth in Article IV. In computing any such maximum limits, benefits paid to or on behalf of any Covered Person under a Predecessor Medicare Supplement Option shall be applied against the maximum limits set forth in Article IV. Without limiting the generality of the foregoing, and by way of example only, benefits paid to or on behalf of a Covered Person under the Medical Assistance Plan Option of the Consolidated Flex Medical Plan, as in effect prior to September 1, 2010, or under any predecessor plan with respect to the Medical Assistance Plan, shall be counted against the maximum limit set forth in Sections 4.04 and 4.05 with respect to the MAP Option and the MAP-Med Only Option. Likewise, benefits paid to or on behalf of a Covered Person under the BSG Medical Supplement Plan Option of the Consolidated Flex Medical Plan, as in effect prior to September 1, 2010, or under any predecessor plan with respect to the BSG Medical Supplement Plan, shall be counted against the maximum limit set forth in Sections 4.11 and 4.12 with respect to the BSG Med Supp Option and the BSG Med Supp (Med Only) Option.

ARTICLE VIII
CONTRIBUTIONS TO THE PLAN

8.01 Employer Contributions. Except as provided in Article IV and subsection 15.02(e), each Employer will contribute to the cost of the Plan. The amount of the Employer contribution shall be determined by the Company or Plan Administrator on an annual basis or as otherwise required by a collective bargaining agreement.

8.02 Covered Person Contributions. As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company. The Covered Person contribution shall be the cost of the Plan less any Employer contribution described in Section 8.01.

ARTICLE IX
PRESCRIPTION DRUG COVERAGE

9.01 **General**. The Plan provides prescription drug coverage in accordance with the provisions in this Article. A prescription drug card shall be issued to each Covered Person which shall provide coverage as set forth in the remainder of this Section.

9.02 **Medicare Part D**. A Covered Person may not be covered by the prescription drug provisions of the MAP Option, the Medigap Supplement Option, the BSG Med Supp Option or any other Post-65 Retiree Coverage Option and a Medicare Part D plan at the same time. If such Covered Person enrolls in a Medicare Part D plan, he will no longer be eligible to participate in a Post-65 Retiree Coverage Option that provides prescription drug coverage. If the Covered Person later loses or drops his or her Medicare Part D coverage, he will not be able to resume participation in a Post-65 Retiree Coverage Option that provides prescription drug coverage.

9.03 **Co-Payments, Co-Insurance and Deductibles**. The amount of prescription drug Co-Payment depends on the category of drug the Covered Participant purchases. The Out-of-Pocket Expense Limitation on prescription drugs for the MAP Option and the BSG Med Supp Option is $750 per person per calendar year. There is no Out-of-Pocket Expense Limitation for the Medigap Supplement Option. There is a $25 Deductible per calendar quarter per Covered Person for the BSG Med Supp Option with respect to Brand drugs only.

(a) *Retail Pharmacy*. For a 30-day supply, a Covered Participant shall pay 20 percent of the cost of the drug, subject to a minimum and maximum cost, as set forth in the table below.

MAP Option			
30-Day Supply	Co-Payment	Minimum	Maximum
Generic	20% of the drug cost	$5	$15
Formulary	20% of the drug cost	$15	$45
Non-formulary	20% of the drug cost	$30	$90

BSG Med Supp Option			
30-Day Supply	Co-Payment	Minimum	Maximum
Generic	0% of the drug cost	NA	NA
Brand	20% of the drug cost	NA	NA

Medigap Supplement Option			
30-Day Supply	Co-Payment	Minimum	Maximum
Generic	20% of the drug cost	$5	$15
Formulary	20% of the drug cost	$15	$45
Non-formulary	20% of the drug cost	$30	$90

(b) *Mail Order.* The Co-Payment for a prescription drug ordered through the mail-order service shall be based on the coverage class of the drug.

MAP Option and Medigap Supplement Option			
90-Day Supply	Co-Payment	Minimum	Maximum
Generic	$10	NA	NA
Formulary	$30	NA	NA
Non-formulary	$60	NA	NA

BSG Med Supp Option			
90-Day Supply	Co-Payment	Minimum	Maximum
Generic	$2	NA	NA
Brand	$15	NA	NA

(c) *Ninety-Day Supply at Retail Program.* Covered Participants in the MAP Option and the Medigap Supplement Option may purchase a 90-day supply (or an 84-91 day supply, in the case of the Medigap Supplement Option) of prescription drugs from a participating retail pharmacy under the Ninety-Day Supply at Retail Program. The Co-Payment for such 90-day supply shall be as set forth in the table below.

MAP Option			
90-Day Supply	Co-Payment	Minimum	Maximum
Generic	100% of the drug cost	$10	$30
Formulary	20% of the drug cost	$30	$90
Non-formulary	100% of the drug cost	$60	$180

Medigap Supplement Option			
90-Day Supply	Co-Payment	Minimum	Maximum
Generic	20% of the drug cost	$10	$30
Formulary	20% of the drug cost	$30	$90
Non-formulary	20% of the drug cost	$60	$180

9.04 Definitions. For purposes of this Section, the following definitions shall apply:

(a) "Generic" means drugs no longer covered by the original patent.

(b) "Formulary" means a list of approved drugs covered under the prescription drug plan.

(c) "Non-formulary" means drugs not chosen for the Formulary, which do not qualify as Generic.

(d) "Brand" means a drug that has been patented and is only available through one manufacturer.

9.05 Items Covered. Items covered under this Section include, without limitation, the following Federal legend drugs and supplies, but excluding any item described in Section 9.06 below:

(a) Insulin;

(b) Disposable insulin needles/syringes;

(c) AZT (Retrovir);

(d) Chemotherapeutics;

(e) Immunosuppressants;

(f) Immune serums;

(g) Diabetic diagnostics;

(h) Contraceptives, except for implants and IUDs;

(i) With respect to the BSG Med Supp Option only, drugs used in the treatment of erectile dysfunction or impotence;

(j) Injectables, other than insulin;

(k) Vitamins (only if prescribed);

(l) Compound medications of which at least one ingredient is a Federal legend drug; and

(m) Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

9.06 Items Not Covered. Items not covered under this Section include, without limitation, the following, in addition to other items that the Plan Administrator determines from time to time are not eligible for coverage:

(a) Drugs or medicines that are lawfully obtainable without the prescription of a Physician, whether or not such drugs are actually obtained by prescription;

(b) Prescription drugs dispensed through a retail pharmacy that is not a member of the network of participating retail pharmacies established by the Plan's pharmacy benefit manager;

(c) Drugs prescribed for cosmetic reasons;

(d) Drugs used for the treatment of infertility or relating to conception;

(e) Hair treatments;

(f) Anti-wrinkle treatment;

(g) Blood glucose testing machines;

(h) Vaccines, serums (except for immune serums) and allergens;

(i) Nutritional dietary supplements;

(j) Certain smoking cessation products;

(k) Over-the-counter medications; and

(l) Any item that is not legally procured, including without limitation any Federal legend drug that may not legally be imported from another county.

9.07 Preauthorization. The Plan may require authorization before it will cover certain drugs. Such authorization shall be requested and granted pursuant to procedures as the Plan may establish.

ARTICLE X
EMPLOYEE ASSISTANCE PROGRAM COVERAGE

10.01 Benefits. Covered Persons may choose to receive Employee Assistance Program benefits for which they are eligible as set forth in the applicable Summary Plan Description.

10.02 Claim for Benefits. Any Covered Participant or beneficiary, or his or her duly authorized representative, may file a claim in accordance with the procedures set forth in the applicable Summary Plan Description for the benefits offered hereunder to which the claimant believes he is entitled, but that have been previously denied by the Plan Administrator.

ARTICLE XI
SUBROGATION

11.01 Subrogation. If an Other Party is liable or legally responsible to pay expenses, compensation and/or damages in relation to a Sickness or an Injury incurred by any Covered Person, and benefits are payable under the Plan in relation to such Sickness or Injury, the Plan shall be subrogated to all rights of recovery of such Covered Person. The Covered Person or his or her legal representative shall transfer to the Plan any rights he may have to take legal action arising from the Sickness or Injury so that the Plan may recover any sums paid on behalf of the Covered Person. If the Covered Person fails to take legal action against an Other Party, and the Plan elects to take such legal action against such Other Party, in addition to the right to recover Plan benefits paid, the Plan shall be entitled to all expenses, including reasonable attorney's fees, incurred for such recovery. If the Plan recovers an amount greater than Plan benefits paid, the excess, reduced by the expenses of recovery, including reasonable attorney's fees, shall be paid to the Covered Person. The Plan shall have the right, with prior notice to, but without the consent of, the Covered Person, to compromise the amount of its claim if, in the opinion of the Plan Administrator, it is appropriate to do so.

11.02 Right of Recovery. The Plan may recover from a Covered Person or his or her legal representative the amount of any benefits paid under the Plan from any payment the Covered Person receives or is entitled to receive from an Other Party. The Plan shall not be responsible for any attorney's fees associated with any payment received by a Covered Person, unless the Plan expressly assumes such obligation prior to the Covered Person's recovery. Accordingly, unless the Plan expressly agrees otherwise, its recovery shall not be offset by any attorney's fees incurred by a Covered Person.

11.03 Application to Funds Recovered. For the avoidance of doubt, the Plan's right of subrogation described in Section 11.01 and its right of recovery described in Section 11.02 apply to any funds recovered from an Other Party by or on behalf a Retiree, a Retiree's covered Dependent, the estate of any Covered Person or any incapacitated person.

11.04 Cooperation Required. The Covered Person or his or her legal representative shall cooperate fully with the Plan in asserting its subrogation and recovery rights. The Covered Person or his or her legal representative shall, upon request from the Plan, provide all information and sign and

return all documents or agreements deemed by the Plan Administrator to be necessary for the Plan to exercise its rights under this Article. No Covered Person shall take any action to prejudice the Plan's subrogation rights. Each Covered Person shall provide notice to the Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. As a condition of participating in the Plan, each Covered Person acknowledges that the Plan has a right to intervene in any lawsuit involving an Other Party, and such Covered Person consents to the unfettered exercise of that right. Failure or refusal to execute any of the aforementioned documents or agreements or to furnish information, to comply with the obligations under such agreements or to cooperate fully with the Plan in asserting its subrogation and recovery rights does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

11.05 First Lien Created. The Plan shall have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or any other means, that the Covered Person receives or is entitled to receive from any Other Party. 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 Plan. Such lien shall not exceed the lesser of:

(a) The amount of benefits paid by the Plan for the Sickness or Injury, plus the amount of all future benefits that may become payable under the Plan that result from the Sickness or Injury. The Plan shall have the right to offset or recover such future benefits from the amount received from the Other Party; or

(b) The amount recovered from the Other Party.

The Plan's first lien rights will not be reduced (1) due to the Covered Person's own negligence; (2) due to the Covered Person not being made whole; or (3) due to any attorney's fees and costs incurred by the Covered Person. Without limiting the generality of the foregoing, neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Plan, and as a condition of participating in the Plan, each 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.

11.06 Constructive 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 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 Plan in accordance with this Article, and that such funds shall be held in a constructive trust until distributed in accordance with this Article.

11.07 Personal Liability Created. If a Covered Person or his or her legal representative makes any recovery from any Other Party and fails to reimburse the Plan for any benefits paid as a result of the Sickness or Injury, then (1) the Covered Person or his or her legal representative shall be personally liable to the Plan for the amount of the benefits paid under the Plan; and (2) the Plan may reduce future benefits payable by the amount of payment that the Covered Person or his or her legal representative has received from the Other Party. If the Plan institutes legal action against a Covered Person who fails to reimburse the Plan as required by this Section, in addition to liability to the Plan for the amount of benefits paid under the Plan, such Covered Person shall

be liable to the Plan for the amount of the Plan's costs of collection, including reasonable attorney's fees.

ARTICLE XII
NONDUPLICATION OF BENEFITS

12.01 General. Nonduplication of Benefits rules set forth the order of payment of Covered Expenses when two or more plans, including Medicare, are liable for payment. This Article shall not apply to benefits obtained by a Covered Person from an individual medical insurance policy under which such Covered Person is entitled to benefits as a named person.

12.02 Definitions. For purposes of this Article, the following definitions shall apply:

(a) "Allowable Expense" shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made.

(b) "Plan" or "Benefit Plan" means this Plan or any one of the following plans:

(1) Group or blanket benefit plans, including health maintenance organizations;

(2) Blue Cross and Blue Shield group plans;

(3) Group practice and other group prepayment plans;

(4) Federal government plans or programs, including Medicare;

(5) Other plans required or provided by law; and

(6) "No fault vehicle insurance," by whatever name it is called, when inclusion is not prohibited by law.

"Plan" or "Benefit Plan" shall not encompass Medicaid or any other plan, program, policy or arrangement that, by its terms, does not allow coordination, integration or carve out of benefits.

(c) "Order of Benefits Determination" shall mean the method for ascertaining the order in which the Plan renders payment hereunder.

12.03 Application of the Rules. The Plan that is obligated to pay its benefits first shall be known as the "Primary" Plan. The Plan that, by its terms, is obligated to pay additional benefits for Allowable Expenses not paid by the Primary Plan is known as the "Secondary" Plan. Where another Plan contains a provision providing for coordination, integration or carve out of benefits, the following Order of Benefits Determination shall establish the responsibility for payment hereunder:

(a) The Plan covering the patient as an employee shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the patient as a Dependent.

(b) The Plan covering the patient as a Dependent of a person with a birthday earlier in the year shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the patient as a Dependent of a person with a birthday later in the year. In the

event of divorce or legal separation, the following order shall establish responsibility for payment.

(1) If a court decree has determined financial responsibility for a Child's health care expenses, the Plan of the parent having that responsibility is Primary. If the parent with financial responsibility has no coverage for the Child's health care expenses, but that parent's Spouse does, such Spouse's Plan is Primary.

(2) The Plan of the parent with custody of the Child pays before the Plan of the other parent or the Plan of any stepparent.

(3) The Plan of the stepparent married to the parent with custody of the Child pays first.

(4) The Plan of the parent without custody of the child pays before the non-custodial stepparent.

If this Order of Benefits Determination is not recognized by the other Plan, the order will be determined at the option of the Claims Administrator on a case by case basis.

(c) Where the order of payment cannot be determined in accordance with (a) and (b) above, the Primary Plan shall be deemed to be the Plan that has covered the patient for the longer period of time.

12.04 Plan As Primary Payor. If this Plan is Primary, it will provide payment in accordance with its terms.

12.05 Plan As Secondary Payor. If this Plan is Secondary, it will provide payment in accordance with its terms, considering as a Covered Expense the amount that would have been a Covered Expense in the absence of the Primary Plan, less the amount payable from the Primary Plan.

12.06 When Other Plan Has No Nonduplication of Benefits Rules. This Plan shall be considered to be Secondary when the other Plan does not contain a coordination, integration or carve-out of benefits provision, or if the other Plan provides that it will be Secondary payor in all instances.

12.07 Vehicle Coverage Limitation. When medical benefits are available under vehicle insurance, this Plan shall always be considered as Secondary regardless of the individual's election under PIP (personal injury protection) coverage with the vehicle insurance carrier.

12.08 If Medicare Is Involved.

(a) General. Notwithstanding anything in the Plan to the contrary, the provisions of this Section apply if Medicare is involved. Medicare shall be deemed to be "involved" if any Covered Person is eligible for benefits from Medicare, regardless of whether such Person has enrolled for coverage under Medicare. A Medicare-eligible Covered Person who fails to enroll for Medicare coverage shall be deemed to be enrolled under all parts of Medicare except Medicare Part D.

(b) Definitions. The following terms have the meanings set forth herein for purposes of this Section:

(1) "Benefits" means any service or supply for which an MA Organization incurs a liability under an MA plan.

(2) "Current Employment Status" has the meaning given such term in 42 C.F.R. § 411.104, or in any successor regulation or provision implementing the Medicare Secondary Payer Rule, 42 U.S.C. § 1395y(b)(1).

(3) "MA" means Medicare Advantage.

(4) "MA Plan Enrollee" means an MA eligible individual who has enrolled in an MA Plan.

(5) "MA Organization" means a public or private entity organized and licensed by a State as a risk bearing entity (with the exception of provider sponsored organizations receiving waivers) that is certified by the Centers for Medicare and Medicaid Services ("CMS") as meeting the requirements for participation in the MA program.

(6) "MA Plan" means health benefits coverage offered under a policy or contract by an MA Organization.

(7) "MA Provider" means any provider authorized to provide medical services or supplies under the MA program.

(8) "MA Provider Network" means the MA Providers with which an MA Organization contracts or makes arrangements to furnish covered health care services to MA Plan Enrollees.

(9) "Medicare" means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as amended.

(10) "Order of Benefits Determination" means the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

(11) "Person" means a person who is eligible for benefits as a Covered Person under this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

(c) Order of Benefits Determination. When Medicare is involved, the Order of Benefits Determination shall be as follows:

(1) For Post-65 Retirees who are Covered Persons, and for their Dependents who are Covered Persons and eligible for Medicare, this Plan will be Secondary payor and Medicare will be Primary payor.

(2) For a Pre-65 Retiree Plan Participant's Dependent who is a Covered Person, this Plan will be Secondary payor and Medicare will be Primary payor.

(3) For Covered Persons eligible for Medicare, either entirely or in part, by reason other than age, the following provisions shall apply:

(A) For persons eligible for Medicare by reason of disability, this Plan will be Secondary payor and Medicare will be Primary payor;

(B) Subject to subparagraph (C) below, for a Covered Person eligible for Medicare by reason of end-stage renal disease, benefits of this Plan shall

be Primary during the initial thirty-month period that begins on the date such Covered Person first becomes eligible for Medicare due to end-stage renal disease. Once the thirty-month period has expired, Medicare shall be Primary.

(C) For a Covered Person eligible for Medicare by reason of end-stage renal disease and for whom Medicare was already Primary at the time such Covered Person became eligible for Medicare due to end-stage renal disease, benefits of this Plan shall continue to be Secondary and Medicare shall be Primary. Provided, however, that Medicare must have been Primary at the time the Covered Person became eligible for Medicare due to end-stage renal disease because all of the following are true: (i) the Covered Person was already entitled to Medicare on the basis of age or disability; (ii) the Covered Person did not have coverage under the Plan by virtue of his or her own Current Employment Status or the Current Employment Status of another Covered Person; and (iii) the Plan was Secondary because it had justifiably taken into account the age-based or disability based Medicare entitlement of the Covered Person.

(4) For Covered Persons who are MA Plan Enrollees, this Plan shall be either a Primary or Secondary payor in accordance with subparagraphs (1), (2) or (3) above.

(d) Payment Provisions. If this Plan is Secondary to Medicare, this Plan will provide payment in accordance with its terms, considering as a Covered Expense the amount that would have been a Covered Expense in the absence of Medicare, less (1) the amount payable from Medicare; and (2) the amount denied by Medicare for which a Covered Person is not legally responsible. An amount shall be deemed "payable" from or "denied" by Medicare without regard for whether the person is enrolled under Medicare. If an MA Plan Enrollee who is a Covered Person receives services or supplies for which no Benefits are payable because such services or supplies are from a provider that is not an MA Provider, or are provided outside of an MA Provider Network, this Plan, if a Secondary payor, shall provide benefits in the same amount as if the Covered Person had received Benefits.

(e) Coordination of Medicare Part D. If a Covered Person has prescription drug coverage under the Plan and Medicare Part D simultaneously, such coverage shall coordinate as provided by law.

ARTICLE XIII
ADMINISTRATION OF PLAN

13.01 Committee to Administer the Plan. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA.

13.02 The Committee. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

13.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Plan;

(h) To determine the status and rights of all Covered Persons;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Plan;

(k) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Plan;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

13.04 Interpretative Authority. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Summary Plan Description thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

13.05 Appointment of the Claims Administrator. The Plan Administrator shall appoint a Claims Administrator to provide administrative services to the Plan Administrator in connection with the operation of the Plan and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons or entity serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

ARTICLE XIV
CLAIMS FOR BENEFITS

14.01 Consideration of Initial Claim.

(a) Filing Initial Claim. The Claims Administrator shall process benefit claims pursuant to the procedures set forth below. Initial claims shall be filed within eighteen months from the date a charge is incurred. The Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator may decide benefit claims requiring a determination of whether an individual meets the requirements for eligibility under the terms of the Plan, which determination may result in a denial, reduction, or termination of, or failure to provide payment for, a benefit. Solely with respect to claims involving a determination of an individual's eligibility under the Plan, the term "Claims Administrator" as used in this Article shall refer also to the Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator.

(b) Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to permit a determination whether, or to what extent, benefits are covered or payable under the Plan. If the claimant does not provide sufficient information for the Claims Administrator to make such determination, then within 24 hours after the Claims Administrator's receipt of the claim, the claimant shall be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he shall have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Claims Administrator shall notify the claimant of its decision regarding the claim within 48 hours of the earlier of (i) the Claims Administrator's receipt of the specified information, or (ii) the end of the period afforded the claimant to provide the specified additional information.

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 the ability of the patient to regain maximum function, or in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the

initial 15-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within five days after receipt of the claim he shall be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Pre-Service Claim" is any claim where the Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide notice of an adverse determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Plan if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, the claimant shall receive notice of the specific information necessary to complete the claim. Once the claimant is notified he shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Post-Service Claim" is any claim that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

(e) Concurrent Care Claims. In the case of an ongoing course of treatment, the claimant shall receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Claims Administrator shall notify the claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. If the request to extend any ongoing course of treatment is not an Urgent Care Claim, the Claims Administrator will treat the claim as either a Pre-Service Claim or a Post-Service Claim (as applicable) and will consider the claim according to the timeframes applicable to Pre-Service Claims or Post-Service Claims, whichever applies. The Claims Administrator shall be solely responsible for handling all Concurrent Care Claims.

A "Concurrent Care Claim" is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding a request by a claimant to extend a course of treatment beyond what has been approved.

14.02 If the Claims Administrator Denies the Initial Claim. If the Claims Administrator denies all or any portion of a claim, it shall provide notice of the denial stating (1) the specific reason for the denial; (2) the specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Plan's

review procedures (as set forth below) and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Claims Administrator denies a claimant's Urgent Care Claim in whole or in part, the Claims Administrator shall provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Claims Administrator shall provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

14.03 Appeal to the Claims Administrator.

(a) General. If the Claims Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for review to the Claims Administrator within 180 days of receipt of the Claims Administrator's notice of claim denial.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he thinks the claim should not have been denied. The claimant's request shall include any denial letter he received and any additional documents, information or comments he thinks may have a bearing on the claim.

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

If the denial 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 consultant 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 the claimant upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Expedited Review for Urgent Care Claims. In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. The Claims Administrator shall notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

14.04 If the Claims Administrator Denies a Claim on Appeal. If the Claims Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

14.05 Appeal to the Claims Administrator of Pre- and Post-Service Claim Denials.

(a) General. If the Claims Administrator denies all or any portion of a Pre-Service Claim or a Post-Service Claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for review to the Claims Administrator within 180 days of receipt of the Claims Administrator's notice of claim denial.

Requests for review should be sent to the Claims Administrator at the address furnished by the Plan Administrator from time to time.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he thinks the claim should not have been denied. The claimant's request shall include any denial letter he received and any additional documents, information or comments he thinks may have a bearing on the claim.

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

If the denial 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 consultant 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 the claimant the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(c) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

14.06 If the Claims Administrator Denies a Claim on Appeal. If the Claims Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner

calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

14.07 Limitations Upon Civil Actions. No civil action regarding a claim for benefits under the Plan may be commenced unless the claims procedure process described in this Article XXI has been exhausted. In addition, in no event may any civil 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.

14.08 Construction of Article. This Article shall be construed in a manner consistent with Department of Labor Regulations governing claims procedures applicable to group health plans.

ARTICLE XV
TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE

15.01 Cessation of Participation. Except as otherwise provided in this Article:

(a) A Post-65 Retiree shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date of the death of the Post-65 Retiree;

(3) The last day of the month in which a Post-65 Retiree is no longer eligible for coverage under Article III, including without limitation as a result of the Post-65 Retiree's former employer no longer being a Related Employer, unless the Plan Administrator determines, in its discretion, that such event shall not cause a loss of coverage;

(4) The Separation Date, with respect to any Post-65 Retiree who retired from employment with a Columbia Divested Company;

(5) The last day of the last month for which any required Covered Person Contribution was made, in the case of cessation of required Covered Person Contributions; or

(6) The date Post-65 Retiree coverage ceases pursuant to any Plan amendment.

(b) A Dependent of a Retiree shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The last day of the month in which the Post-65 Retiree's coverage under the Plan, or the Pre-65 Retiree Plan Participant's coverage under the Consolidated Flex Plan ends, except that if coverage ends due to the death of a Retiree within 30 days preceding, or at any time on or after, May 1, 2010, and if COBRA or COBRA-like continuation coverage is elected pursuant to Section 15.02 by or on behalf of such Dependent who is a Qualified Beneficiary and such coverage is not terminated prior to the maximum continuation coverage period specified in Section 15.02 being exhausted, then coverage under the Plan may be continued for such Dependent until the earlier of (i) the date of the death of the Retiree's Spouse or Same-Sex Domestic Partner; (ii) the last day of the month in which the Retiree's Spouse or Same-Sex Domestic Partner remarries or enters into a domestic partnership or civil union with another person; (iii) the last day of the last month for which any required Covered Person Contributions for such coverage are made, in the case of cessation of required Covered Person Contributions; (iv) with respect to a Dependent Child, the last day of the month in which such Dependent would no longer be considered a Dependent under the Plan, had the Retiree survived; (v) the Separation Date, in the case of a Retiree who retired from employment with a Columbia Divested Company; and (vi) the date the Employer from whom the Retiree retired from employment ceases to be a Related Employer, unless the Plan Administrator determines, in its discretion, that such event shall not cause a loss of coverage. If such Dependent's COBRA or COBRA-like continuation coverage pursuant to Section 15.02 has terminated for any reason before the maximum COBRA continuation coverage period has been exhausted, no further coverage is available under the Plan;

(3) The last day of the last month for which any required Covered Person Contributions for Dependent coverage were made, in the case of cessation of required Covered Person Contributions; or

(4) The last day of the month in which a Dependent no longer qualifies as a Dependent.

15.02 COBRA. The Plan offers continuation of coverage to the extent required by COBRA.

(a) Continuation of Coverage. If Plan coverage ends because of a Qualifying Event, a Qualified Beneficiary may elect to continue the Coverage Option in force immediately prior to the Qualifying Event, subject to the provisions below.

(b) Election Period. A Qualified Beneficiary may elect COBRA Continuation Coverage only during the election period. The election period begins on the date of the Qualifying Event and ends on the later of (1) 60 days after the date coverage would have stopped due

to the Qualifying Event; or (2) 60 days after the date the Qualified Beneficiary is sent notice of the right to continue coverage under COBRA.

A Covered Employee or Spouse's election of COBRA Continuation Coverage shall be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

If COBRA Continuation Coverage is elected within the election period, coverage shall be reinstated retroactively to the date of the Qualifying Event. If a Qualified Beneficiary waives COBRA Continuation Coverage during the election period, the Qualified Beneficiary may revoke that waiver at any time before the end of the election period and elect COBRA Continuation Coverage retroactive to the date of the Qualifying Event.

(c) Coverage Period. COBRA Continuation Coverage shall begin as of the date of the Qualifying Event and shall continue until the earliest of the following dates:

(1) 36 months from the date coverage would have ended due to a Qualifying Event.

(2) The date on which the Company ceases to provide any Group Health Plan to any Employee.

(3) If the Qualified Beneficiary fails to make a required Covered Person Contribution, the end of the period for which the last Contribution was made.

(4) The date the 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, and such pre-existing condition limitation is permissible pursuant to HIPAA.

(5) In the case of a Qualifying Event described in subsection 2.81(d), the date of death of the Retiree or, for a Qualified Beneficiary described in subsection 2.80(b) who is the surviving Spouse or Dependent Child of the Retiree, the earlier of the date of such Qualified Beneficiary's death or 36 months after the date of the death of the Retiree.

(6) The Separation Date, in the case of a person (A) who is or was a dependent of a former employee of the Company, a Related Employer, a CPG Related Employer, or a Columbia Divested Company, if the former employee's last employment with any of such parties prior to termination of employment was with a CPG Related Employer or a Columbia Divested Company; and (B) whose coverage under the Plan ended prior to the Separation Date because of a Qualifying Event.

(d) Notification Requirements. A Qualified Beneficiary shall notify the Plan Administrator within 60 days of the Qualifying Events set forth in subsection 2.81(b) or (c). If such notice is not given, the Qualified Beneficiary shall not be eligible for COBRA Continuation Coverage.

(e) Required Contributions. Except as provided in subsection 15.02(f), the Company will not make any contribution toward the cost of COBRA Continuation Coverage. A Qualified Beneficiary electing COBRA Continuation Coverage shall be responsible for a Covered Person Contribution in the amount of 102% of what is calculated to be the total

cost of the Coverage Option being continued. Premiums for the period of COBRA Continuation Coverage prior to the date of the election will be due 45 days after the COBRA Continuation Coverage is elected. Thereafter, monthly premiums shall be due the first day of the calendar month. There shall be a grace period of 30 days for the payment of regularly scheduled monthly premiums.

(f) Subsidized COBRA. The Company may subsidize all or a portion of the cost of COBRA Continuation Coverage. If the Company so elects, the period of such subsidized coverage shall count towards the COBRA Continuation Coverage period required under this Section.

(g) COBRA-Like Continuation Coverage for Same-Sex Domestic Partners. The Plan will make COBRA-like continuation coverage available to a Same-Sex Domestic Partner who is a Covered Person (and to a Same-Sex Domestic Partner's Child who is a Covered Person) under circumstances, and subject to the same, terms, conditions and limitations, that would entitle the lawful Spouse or Child of a Covered Participant to elect COBRA continuation coverage. A Same-Sex Domestic Partner and a Child of a Same-Sex Domestic Partner shall have the same notice and other obligations with respect to such continuation coverage as a lawful Spouse or Child of a Covered Participant has with respect to COBRA continuation coverage. For purposes of this COBRA-like continuation coverage, a termination of a same-sex domestic partner relationship will be treated as a divorce.

ARTICLE XVI
PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION

16.01 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 Plan must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

16.02 Permitted Uses and Disclosure. The Plan may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plan 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 Plan or the Privacy Standards.

16.03 Disclosures to Company. The Plan 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 Plan 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.

The Company, in its capacity as sponsor of the Plan, agrees to:

(a) not use or further disclose Protected Health Information received from the Plan other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

(c) not use or disclose Protected Health Information received from the Plan for employment-related actions and decisions;

(d) not use or disclose Protected Health Information received from the Plan in connection with any other benefit or employee benefit plan of the Company (except to the extent that such other benefit, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan is a part);

(e) report to the Privacy Official, acting on behalf of the Plan, any use or disclosure of Protected Health Information received from the Plan that is inconsistent with the uses or disclosures authorized by this Section and of which the Company becomes aware;

(f) make available Protected Health Information in accordance with 45 C.F.R. § 164.524 (pertaining to an individual's access to his or her own Protected Health Information) and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(g) make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(i) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("HHS") or to any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with 45 C.F.R. Subchapter C, Subpart E; and

(j) if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The foregoing restrictions do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the Company or any other Employer, acting in their respective capacities as an employer.

16.04 Adequate Separation. There shall be adequate separation between the Plan and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the following employees, classes of employees or other persons under the control of the Company or its affiliates may have access to Protected Health Information created under the Plan:

Privacy Official
Security Official
Members of the Benefits Department
HRIS-Benefits Analyst
Members of the Legal Department
Members of the Internal Audit Department
Members of the Committee
Any other employee of the Company or its affiliates who performs plan administration functions for the Plan and who is designated in writing by the Privacy Official or a member of the Committee as being entitled to access to Protected Health Information.

Access to and use by such individuals shall be restricted to the plan administration functions that the Company and its affiliates perform for the Plan. The Plan or the Company (or an affiliate) has 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 Plan. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plan governing their obligations under the Privacy Standards.

16.05 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 Plan. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

16.06 Special Amendatory Authority. The Privacy Official appointed by the Plan Administrator pursuant to the Privacy Standards shall be authorized to make and execute any amendment to this Article that such Privacy Official deems necessary or appropriate.

ARTICLE XVII
PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

17.01 General. The Department of Health and Human Services has issued Regulations, effective April 20, 2005, that govern the manner in which a group health plan, such as the Plan, must handle Electronic Protected Health Information. "Electronic Protected Health Information" refers to Protected Health Information that is (i) maintained in Electronic Media (as defined in 45 C.F.R. Section 160.103), or (ii) transmitted by Electronic Media.

17.02 Duty of the Plan Sponsor. The Company shall reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted to or by the Company on behalf of the Plan. To this end, the Company shall: (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Company creates, receives, maintains or transmits on behalf of the Plan; (ii) ensure that the adequate separation required by Section 16.04 above is supported by reasonable and appropriate security measures; (iii) ensure that any agent, including a subcontractor, to whom or which the Company provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and (iv) report to the

Plan any security incident involving Electronic Protected Health Information of which the Company becomes aware.

ARTICLE XVIII
GENERAL EXCLUSIONS

18.01 General. Notwithstanding any other Plan provision, and without limiting the generality of any other provision of the Plan, the Plan shall not provide coverage for any of the following:

(a) except as expressly provided otherwise in the Plan, any service, supply or item for which Medicare does not make any payment;

(b) any charge that a Covered Person is not legally required to pay;

(c) any charge that would not have been made if the Plan had not existed; and

(d) any charge incurred prior to the effective date of coverage, or after the termination date of coverage.

ARTICLE XIX
MISCELLANEOUS PROVISIONS

19.01 Assignment of Benefits. Except as required by applicable law, no right or interest of any Covered Person, and no benefit payable at any time, under the 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 the Plan be liable for, or subject to, any obligation or liability of any Covered Person. Without limiting the generality of the foregoing, except as required by applicable law, no Covered Person may 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 the 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 the Plan, and any such attempted assignment or transfer is void.

Nothing contained herein, nor any course of dealing, act or omission on the part of the Plan, the Plan Administrator or any Claims Administrator or other party, shall be construed to make the Plan liable to any third party to whom a Covered Person may be liable for medical care, treatment, services or supplies. Although the Plan may, at the direction of a Covered Person or otherwise, make payments directly to persons or institutions providing covered services under the Plan, no such direction or payment shall be deemed to constitute an assignment, or an acknowledgment or acceptance of any purported assignment, of any benefits or other rights or interests under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by the Plan shall constitute a complete discharge of the obligation of the Plan to such Covered Person. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to a Covered Person be deemed a participant or beneficiary under the Plan.

If any Covered Person entitled to a benefit under the Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part, or if by reason of his or her bankruptcy

or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then upon becoming aware of any 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 his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her Dependents, in a manner the Plan Administrator may deem proper.

19.02 Information To Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

19.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

19.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Covered Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

19.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

19.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

19.07 Misrepresentation. Any material misrepresentation on the part of any Covered Person in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void.

19.08 Inadvertent Error. Inadvertent error by the Plan Administrator in the keeping of records or the transmission of any Enrollment Form shall not deprive any Covered Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

19.09 No Liability for Acts of Any Provider. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan for the acts of any Hospital in which he receives care, or for the acts of any Physician from whom he receives service under this Plan.

19.10 Covered Persons Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect; (2) the Covered Person does not respond to the notice sent to the current address; (3) there are conflicting claims to such payment; or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest. Each Covered Participant shall also notify the Plan in writing when any person is no longer eligible for coverage as his or her Dependent hereunder.

19.11 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to offset the overpaid amount against future benefits that are payable or to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization. Without limiting the generality of the foregoing, the Plan shall have the right to recover any amounts it pays in respect of a person who is not an eligible Participant or Dependent.

19.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 19.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

19.13 Severability. In the event any portion of this Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Plan, and the balance of the Plan shall remain in full force and effect.

19.14 Participant Litigation. In any action or proceeding involving the Plan, Covered Persons or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

19.15 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

19.16 Notice. Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Claims Administrator, when addressed to it at its home office; or if given to a Covered Participant, when addressed to the Covered Participant at his or her address as it appears on the records of the Claims Administrator.

19.17 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees and Retirees to become Covered Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XX
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

20.01 Plan Self-Insured. Except with respect to those benefits offered under an HMO Option or an Other Insured Arrangement, the Plan is a self-insured plan. All contributions made to the Plan are used to pay claims and related expenses thereunder.

20.02 Participants' and Dependents' Rights Unsecured. The right of a Covered Person or any other person to receive a distribution hereunder, shall be an unsecured claim against the general assets of the Company and no Covered Person or any other person shall have any rights in any amount allocated for his or her benefit under the terms of the Plan, or any other specific assets of the Company. All amounts allocated pursuant to the terms of the Plan shall constitute general assets of the Company and may be disposed of by the Committee at such time and for such purpose as it may deem appropriate. Benefits payable pursuant to the terms of the Plan shall be paid solely as required out of the general assets of the Company or from any other funding vehicle as may be established by the Company.

20.03 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Unless expressly provided, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration. To the extent that any applicable collective bargaining agreement imposes a more restrictive requirement regarding Plan eligibility or benefits than is set

forth herein, such requirement, as applied solely to those Represented Retirees subject to the collective bargaining agreement, is incorporated herein by this reference. Notwithstanding anything contained herein to the contrary, any change or amendment (other than a Plan administration change, the addition or deletion of network providers, drug formulary changes or similar changes) affecting coverage for any NIPSCO Represented Retiree or Dependent shall only be made effective as of January 1 of any year, and notification of such change or amendment shall be made to affected NIPSCO Represented Retirees during the Annual Enrollment Period.

20.04 **Termination**. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions to, or to maintain, the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

20.05 **Collective Bargaining Agreement**. Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Remainder of page intentionally left blank]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 19th day of December, 2017, to be effective as of January 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

SCHEDULE 1
POST-65 RETIREE BENEFIT PROGRAM MATRIX

Summary of Post-65 Medical Plan Provisions

This section highlights the key post-65 medical plan provisions reflected in the December 31, 2015 measurement.

Eligibility for Participation	Immediate. Groups excluded from coverage are noted in table below.
Eligibility for Benefits	Age 55 and 10 years of service.
Continuation to Spouses of Deceased Retirees	Coverage continues until death of spouse or until spouse remarries.
Available Coverage[1]	Medicare Supplement NIPSCO Union Medicare Supplement MAP MAP (Medical Only) BSG Med Supp BSG Med Supp (Medical Only) BSG Med Supp Multiunion Medigap Supplement Keystone Blue West PA—Central
Medical Plan Options	See table below.
Cost Sharing	See table below.

[1] For detail on specific plan benefit provisions, see applicable NiSource plan documents.

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
101	All Nonunion Exempt FT retired on or after 02/01/2004 and before 02/01/2006 and Non-Exempt FT retired on or after 02/01/2004 and hired before 01/01/2013	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	$450 annually for retiree only	N/A
101A	Bay State Nonunion FT retired on or before 01/01/2002	BSG Med Supp BSG Med Supp MultiUnion	100% of premium	N/A	N/A	N/A
101B	Bay State Nonunion FT retired after 01/01/2002 and age 45 or older as of 01/01/1992 and hired before 09/01/1990 and elected retiree medical coverage and waived special saving plans match	BSG Med Supp BSG Med Supp MultiUnion	100% of premium	N/A	N/A	N/A
101C	Bay State Nonunion FT retired between 01/01/2002 and 02/01/2004	Medicare Supplement	100% of premium	N/A	N/A	N/A
101D	CEG Nonunion FT retired before 01/01/1993	MAP MAP—Med Only	50% of premium	$104.90[1] monthly for retiree only	N/A	N/A
101E	CEG Nonunion FT retired after 01/01/1993 and before 02/01/2004 and hired before 01/01/1993	MAP MAP—Med Only Keystone Blue West PA—Central	50% of premium (0% of premium for Keystone Blue)	$104.90[1] monthly for retiree only	N/A	N/A
101F	CEG Nonunion FT retired after 01/01/1993 and before 02/01/2004 and hired after 01/01/1993	MAP MAP—Med Only	50% of premium	$104.90[1] monthly for retiree only	N/A	N/A
101G	Columbia Nonunion FT—2002 ERW/VSP Age 50–52 (Salary continuation)	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
101H	Columbia Nonunion FT—2002 ERW/VSP Group Age 53–55, retired on or after 02/01/2004	Medicare Supplement MAP MAP—Med Only	50% of premium	$104.90[1] monthly for retiree only	N/A	N/A

[1] Adjusted annually by CMS to equal 25% of the estimated Part B program cost.

GAS-RR-024
Attachment E
Page 74 of 84

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
101I	Kokomo Nonunion FT retired before 01/01/2002	Medicare Supplement	100% of premium	N/A	N/A	N/A
101J	Kokomo Nonunion FT retired between 01/01/2002 and 02/01/2004	Medicare Supplement	100% of premium	N/A	N/A	N/A
101K	NiSource Nonunion FT retired on or before 02/01/1997	Medicare Supplement	100% of premium	N/A	N/A	N/A
101L	NiSource Nonunion FT retired after 02/01/1997 and before 02/01/2004	Medicare Supplement	100% of premium	N/A	N/A	N/A
101M	NIFL FT retired before 01/01/2002	Medigap Supplement	100% of premium	N/A	N/A	N/A
101N	NIFL FT retired after 01/01/2002 and prior to 02/01/2004; retirement eligible as of 12/31/2001	Medigap Supplement	100% of premium	N/A	N/A	N/A
101O	NIFL FT retired after 01/01/2002 and retired prior to 02/01/2004 and not retirement eligible as of 01/01/2002	Medicare Supplement	100% of premium	N/A	N/A	N/A
102	All Nonunion Exempt PT retired on or after 02/01/2004 and before 02/01/2006 and Non-Exempt PT retired on or after 02/01/2004 and hired before 01/01/2013	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	$450 annually for retiree only	N/A
102D	Columbia Nonunion PT—2002 ERW/VSP Age 50–52	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
104	All Nonunion Exempt FT retired on or after 02/01/2006 and hired before 01/01/2010	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	$450 annually for retiree only	N/A
105	All Nonunion Exempt PT retired on or after 02/01/2006 and hired before 01/01/2010	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	$450 annually for retiree only	N/A

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
132	Special 4th Quarter FT VSP retired before 02/01/2004	Medicare Supplement	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
221	NIPSCO Union FT retired prior to 01/01/2005	NIPSCO Union Medicare Supplement	100% of premium	N/A	N/A	N/A
221Y05	NIPSCO Union FT hired before 06/01/2004 and retired on or after 01/01/2005 and before 01/01/2015	NIPSCO Union Medicare Supplement	77% of premium	N/A	N/A	$40 per month for retiree only
221Y14	NIPSCO Union FT retired before 01/01/2015 and hired on or after 06/01/2004 and before 06/01/2009	NIPSCO Union Medicare Supplement	70% of premium	N/A	N/A	$40 per month for retiree only
221Y15	NIPSCO Union FT hired before 06/01/2004 and retiring on or after 01/01/2015	NIPSCO Union Medicare Supplement	Retirements before 01/02/2017 get choice between: (a) Defined Dollar $60 x service retiree[1] $40 x service spouse[2] (b) 77% of premium Retirements on or after 01/02/2017 get Defined Dollar as described above.	N/A	$475 annually for retiree only (if elect Defined Dollar)	$40 per month for retiree only

[1] Defined Dollar increases to $65 x service effective 01/01/2017.
[2] Defined Dollar increases to $45 x service effective 01/01/2017.

GAS-RR-024
Attachment E
Page 76 of 84

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NISource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
225Y15	NIPSCO Union FT retiring after 01/01/2015, and hired on or after 06/01/2004 and before 06/01/2009	NIPSCO Union Medicare Supplement	Retirement before 01/02/2017 get choice between: (a) Defined Dollar $60 x service retiree[1] $40 x service spouse[2] (b) 70% of premium Retirements on or after 01/02/2017 get Defined Dollar as described above.	N/A	$475 annually for retiree only (if elect DD)	$40 per month for retiree only
226	NIPSCO Union FT hired on or after 06/01/2009 and retiring on or after 6/1/2019	NIPSCO Union Medicare Supplement	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	$475 annually for retiree only	$40 per month for retiree only
321	NIFL Union FT retired on or after 01/01/2006 but before 01/01/2012	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	$450 annually for retiree only	N/A
321Y12	NIFL Union FT retired on or after 01/01/2012 and before 01/01/2015 and hired before 01/01/2012	NIPSCO Union Medicare Supplement	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	$475 annually for retiree only	$40 per month for retiree only
321Y15	NIFL Union FT retired on or after 01/01/2015 and hired before 01/01/2012	NIPSCO Union Medicare Supplement	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	$475 annually for retiree only	$40 per month for retiree only
621	CEG Union FT retired after 01/01/2004 but hired before 01/01/2013	Medicare Supplement MAP MAP—Med Only Keystone Blue West PA—Central	Defined Dollar $60 x service retiree $40 x service spouse (100% of premium for Keystone Blue)	N/A	$450 annually for retiree only	N/A

[1] Defined Dollar increases to $65 x service effective 01/01/2017.
[2] Defined Dollar increases to $45 x service effective 01/01/2017.

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
621A	CEG Union FT retired before 01/01/1993	MAP MAP—Med Only Keystone Blue West PA—Central	50% of premium (100% of premium for Keystone Blue)	$104.90[1] monthly for retiree only	N/A	N/A
621B	CEG Union FT retired after 01/01/1993 and before 02/01/2004 and hired before 01/01/1993	MAP MAP—Med Only Keystone Blue West PA—Central	50% of premium (100% of premium for Keystone Blue)	$104.90[1] monthly for retiree only	N/A	N/A
621C	CEG Union FT retired after 01/01/1993 and before 02/01/2004 and hired after 01/01/1993	MAP MAP—Med Only	50% of premium	$104.90[1] monthly for retiree only	N/A	N/A
621D	CEG Union FT—2002 ERW/VSP Group Age 50–52 (Salary Continuation)	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
621E	CEG Union FT—2002 ERW/VSP Group Age 53–55, retired on or after 02/01/2004	MAP MAP—Med Only	50% of premium	$104.90[1] monthly for retiree only	N/A	N/A
622	CEG Union PT retired after 02/01/2004 and hired before 01/01/2013	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	$450 annually for retiree only	N/A
622C	CEG Union PT retired after 01/01/1993 and before 02/01/2004 and hired on or after 01/01/2003	MAP MAP—Med Only	50% of premium	$104.90[1] monthly for retiree only	N/A	N/A
721Y05	Kokomo Union FT Outside (majority) retired after 01/01/2005 but before 01/01/2012	Medicare Supplement MAP MAP—Med Only	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A

[1] Adjusted annually by CMS to equal 25% of the estimated Part B program cost.

GAS-RR-024
Attachment E
Page 78 of 84

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
721Y12	Kokomo Union FT retired on or after 01/01/2012 and before 01/01/2015 and hired before 01/01/2012	NIPSCO Union Medicare Supplement	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	$475 annually for retiree only	$40 per month for retiree only
721Y15	Kokomo Union FT retired on or after 01/01/2015 and hired before 01/01/2012	NIPSCO Union Medicare Supplement	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	$475 annually for retiree only	$40 per month for retiree only
821	Bay State Union Brockton Physical FT hired before 01/01/2013 and does not meet requirements of 821A	BSG Med Supp BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
821A	Bay State Union Brockton Physical FT hired before 03/01/1991 and age 45 on 09/01/1991	BSG Med Supp BSG Med Supp (Med Only)	100% of premium	N/A	N/A	N/A
822	Bay State Union Brockton C/T FT and hired before 06/01/2013 and retired before 05/01/2013 and does not meet requirements of 822A	BSG Med Supp BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
822A	Bay State Union Brockton C/T FT hired before 10/01/1990 and age 45 by 01/01/1992	BSG Med Supp BSG Med Supp (Med Only)	100% of premium	N/A	N/A	N/A
822Y13	Bay State Union Brockton C/T FT hired before 06/01/2013 and retired on or after 05/01/2013	BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
823	Bay State Union Granite FT retired after 01/01/2004	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A

[1] Defined Dollar increases to $65 x service effective 01/01/2017.
[2] Defined Dollar increases to $45 x service effective 01/01/2017.

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
823A	Bay State Union Granite FT hired before 05/01/1991 and age 45 by 05/01/1991 and retired before 01/01/2004	BSG Med Supp MultiUnion	100% of premium	N/A	N/A	N/A
824	Bay State Union Lawrence FT retired after 01/01/2004 and retired before 01/01/2013 and does not meet requirements of 824A	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
824A	Bay State Union Lawrence FT hired before 01/01/1994 and age 45 by 01/01/1994 and retired before 01/01/2013	BSG Med Supp BSG Med Supp (Med Only)	100% of premium	N/A	N/A	N/A
824Y13	Bay State Union Lawrence FT hired before 01/01/2013 and retired on or after 01/01/2013	BSG Med Supp BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree $40 x service spouse	N/A	N/A	N/A
825	Bay State Union Northhampton FT hired after 06/18/1999 but before 01/01/2011	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
825A	Bay State Union Northhampton FT hired before 06/18/1999 and at least age 45 on 01/01/1993	BSG Med Supp BSG Med Supp (Med Only)	100% of premium	N/A	N/A	N/A
825B	Bay State Union Northhampton FT hired before 06/18/1999 and not age 45 on 01/01/1993 and retired before 01/01/2013	BSG Med Supp BSG Med Supp (Med Only)	Up to $225 per month	N/A	N/A	N/A
825B13	Bay State Union Northhampton FT hired before 06/18/1999 and not age 45 on 01/01/1993 and retiring between 01/01/2013 and 12/31/2015	BSG Med Supp (Med Only)	Up to $225 per month	N/A	N/A	N/A

GAS-RR-024
Attachment E
Page 80 of 84

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
825B16	Bay State Union Northhampton FT hired before 06/18/1999 and not age 45 on 01/01/1993 and retiring on or after 01/01/2016	BSG Med Supp (Med Only)	Up to $225 per month	N/A	N/A	N/A
826	Bay State Union Portland FT retired after 01/01/2004 and does not meet requirements of 826A	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
826A	Bay State Union Portland FT hired before 04/01/1991 and age 45 by 04/01/1991	BSG Med Supp MultiUnion	100% of premium	N/A	N/A	N/A
827	Bay State Union Portsmouth FT hired after 06/04/1999	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
827A	Bay State Union Portsmouth FT hired before 06/04/1999 and age 45 on 01/01/1993	BSG Med Supp MultiUnion	100% of premium	N/A	N/A	N/A
827B	Bay State Union Portsmouth FT hired before 06/04/1999 and not age 45 on 01/01/1993	BSG Med Supp MultiUnion	Up to $225 per month	N/A	N/A	N/A
828	Bay State Union Springfield Physical FT hired after 05/14/1999 and retired before 05/15/2013	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
828A	Bay State Union Springfield Physical FT hired before 05/14/1999 and at least age 45 on 01/01/1993	BSG Med Supp BSG Med Supp (Med Only)	100% of premium	N/A	N/A	N/A
828B	Bay State Union Springfield Physical FT hired before 05/14/1999 and not age 45 on 01/01/1993 and retired before 05/15/2013	BSG Med Supp BSG Med Supp (Med Only)	Up to $225 per month	N/A	N/A	N/A

GAS-RR-024
Attachment E
Page 81 of 84

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
828B13	Bay State Union Springfield Physical FT hired before 05/14/1999 and not age 45 on 01/01/1993 and retired between 05/15/2013 and 12/31/2013	BSG Med Supp BSG Med Supp (Med Only)	Up to $225 per month	N/A	N/A	N/A
828B14	Bay State Union Springfield Physical FT hired before 05/14/1999 and not age 45 on 01/01/1993 and retired on or after 01/01/2014	BSG Med Supp (Med Only)	Up to $225 per month	N/A	N/A	N/A
828Y13	Bay State Union Springfield Physical FT hired after 05/14/1999 and before 01/01/2014 and retired on or after 05/15/2013	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
829	Bay State Union Springfield C/T FT retired after 01/01/2004 and retired on or before 01/01/2008 and does not meet the requirements of 829A	COBRA Active Medical, if retired after Medicare eligibility date	None	N/A	N/A	N/A
829A	Bay State Union Springfield C/T FT hired before 10/01/1990 and age 45 by 01/01/1992	BSG Med Supp BSG Med Supp (Med Only)	100% of premium	N/A	N/A	N/A
829Y08	Bay State Union Springfield C/T FT retired after 01/01/2008 and retired before 01/01/2011 and does not meet the requirements of 829A	BSG Med Supp BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	N/A	N/A

[1] Defined Dollar increases to $65 x service effective 01/01/2019.
[2] Defined Dollar increases to $45 x service effective 01/01/2019.

GAS-RR-024
Attachment E
Page 82 of 84

Retiree Benefit Program (RBP)	Group	Medicare Medical Options	Company Subsidy	Medicare Part B Reimbursement	NiSource Part B Reimbursement	NIPSCO Medicare Part D Reimbursement
829Y11	Bay State Union Springfield C/T FT hired before 01/01/2011 and between 01/01/2011 and 12/31/2015 and does not meet the requirements of 829A	BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	N/A	N/A
829Y16	Bay State Union Springfield C/T FT hired before 01/01/2011 and retired after 01/01/2016 and does not meet the requirements of 829Y11	BSG Med Supp (Med Only)	Defined Dollar $60 x service retiree[1] $40 x service spouse[2]	N/A	N/A	N/A

[1] Defined Dollar increases to $65 x service effective 01/01/2019.
[2] Defined Dollar increases to $45 x service effective 01/01/2019.

Active Programs That Will Not Receive Retiree Benefits

Active Benefit Program	Group
106	All Nonunion Exempt FT hired after 01/01/2010
107	All Nonunion Exempt PT hired after 01/01/2010
108	All Nonunion Non-Exempt FT hired on or after 01/01/2013
109	All Nonunion Non-Exempt PT hired on or after 01/01/2013
222	NIPSCO Union PT
223	NIPSCO Union TMP
224	NIPSCO Union TWF
623	CEG Union FT hired on or after 01/01/2013
624	CEG Union PT hired on or after 01/01/2013
830	Bay State Union Springfield C/T PT hired before 01/01/2011
831	Bay State Union Brockton Physical FT hired on or after 01/01/2013
832	Bay State Union Brockton C/T FT hired on or after 06/01/2013 and retired after 05/01/2013
834	Bay State Union Brockton Physical PT hired before 01/01/2013
835	Bay State Union Northhampton FT hired on or after 01/01/2011
838	Bay State Union Springfield Physical FT hired on or after 01/01/2014
839	Bay State Union Springfield C/T FT hired on or after 01/01/2011
840	Bay State Union Springfield C/T PT hired on or after 01/01/2011
844	Bay State Union Brockton Physical PT hired on or after 01/01/2013
854	Bay State Union Lawrence FT hired on or after 01/01/2013

NISOURCE LIFE AND MEDICAL BENEFITS PROGRAM

As Amended and Restated
Effective as of January 1, 2015

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Program 1
1.02 Program Components 1
ARTICLE II DEFINITIONS 1
2.01 "Claims Administrator" 1
2.02 "Code" 1
2.03 "Committee" 1
2.04 "Company" 1
2.05 "Component Welfare Plan" 1
2.06 "Concurrent Care Claim" 1
2.07 "Covered Person" 2
2.08 "Disability Benefit Claim" 2
2.09 "Employee" 2
2.10 "Employer" 2
2.11 "ERISA" 2
2.12 "Former Employee" 2
2.13 "Group Health Plan" 2
2.14 "Group Health Plan Claim" 2
2.15 "Participant" 2
2.16 "Participant Contribution" 2
2.17 "Program" 2
2.18 "Plan Administrator" 2
2.19 "Related Employer" 3
2.20 "Urgent Care Claim" 3
ARTICLE III PARTICIPATION 3
3.01 Eligibility 3
3.02 Termination of Participation 3
ARTICLE IV FUNDING AND BENEFITS 3
4.01 Funding 3
4.02 Benefits. 3
ARTICLE V ADMINISTRATION OF PROGRAM 3
5.01 Committee to Administer the Program 3
5.02 The Committee 4
5.03 Powers of the Plan Administrator 4
5.04 Interpretative Authority 5
5.05 Appointment of Claims Administrators 5
5.06 Limitation on Liability 5
ARTICLE VI CLAIMS FOR BENEFITS 5
6.01 Component Welfare Plan Claims Procedures 5
6.02 Consideration of Initial Claim 6
6.03 If the Claims Administrator Denies the Initial Claim 7
6.04 Appeal to the Claims Administrator 8
6.05 If the Claims Administrator Denies a Claim on Appeal 9
6.06 Appeal to the Plan Administrator of Pre- and Post-Service Claim Denials. 10

TABLE OF CONTENTS
(continued)

Page

6.07 If the Plan Administrator Denies a Claim on Appeal 11
6.08 Limitations Upon Civil Actions 12
6.09 Construction of Section 12

ARTICLE VII MISCELLANEOUS PROVISIONS 12
7.01 Assignment of Benefits 12
7.02 Information To Be Furnished 13
7.03 Limitation of Rights 13
7.04 Program Not Contract 13
7.05 No Limitation of Management Rights 13
7.06 Fiduciary Operation 13
7.07 No Guaranty 13
7.08 Covered Person's Responsibilities 13
7.09 Right of Recovery 13
7.10 Governing Law and Venue 14
7.11 Severability 14
7.12 Participant Litigation 14
7.13 Counterparts 14
7.14 Conflict Between Program and Component Welfare Plan 14
7.15 Notice 14
7.16 Extension of Program to Related Employers 15
7.17 Construction 15

ARTICLE VIII AMENDMENT AND TERMINATION OF THE PLAN 15
8.01 Amendment 15
8.02 Termination 15
8.03 Collective Bargaining Agreement 15

EXHIBIT A COMPONENT WELFARE PLANS .....

ARTICLE I
INTRODUCTION

1.01 Purpose of Program. NiSource Inc. established the NiSource Life and Medical Benefits Program effective as of January 1, 2008 for the purpose of consolidating and combining into a single ERISA plan certain component welfare benefit plans maintained by the Company, and to provide Participants and their beneficiaries with the benefits described thereunder and in the Component Welfare Plans, which Component Welfare Plans were, and are hereby, incorporated into the Program as if the same were fully rewritten herein. Notwithstanding the number and types of benefits incorporated hereunder, the Program is, and shall be treated as, a single benefit plan to the extent permitted under ERISA. The Program is intended to meet all applicable requirements of ERISA, as well as rulings and regulations issued thereunder. This plan document is an amendment and restatement of the Program, effective as of January 1, 2015, that reflects certain plan design changes.

1.02 Program Components. The Program's Component Welfare Plans are described in Exhibit A attached hereto and incorporated herein by this reference, as the same may be amended or modified from time to time.

ARTICLE II
DEFINITIONS

The following words and phrases as used in this Program shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

2.01 "Claims Administrator" means the person, persons, entity or entities appointed by the Plan Administrator to process benefit claims pursuant to Section 5.05.

2.02 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.03 "Committee" means the NiSource Benefits Committee.

2.04 "Company" means NiSource Inc., a Delaware corporation.

2.05 "Component Welfare Plan" means each written arrangement incorporated under this Program that is sponsored and/or maintained by the Company and that provides any employee benefit which would be treated as one or more "employee welfare benefit plans" under Section 3(1) of ERISA if offered in the absence of this Program, as such arrangement may be modified and amended from time to time. Each Component Welfare Plan under the Program is identified in Exhibit A, as updated from time to time.

2.06 "Concurrent Care Claim" means, with respect to benefits provided under a Group Health Plan, (a) a claim in respect of any reduction or early termination of treatment in the case of an ongoing course of treatment to be provided over a period of time or number of treatments, or (b) a request

by a claimant that is an Urgent Care Claim to extend an ongoing course of treatment beyond the specified period of time or number of treatments.

2.07 **"Covered Person"** means an Employee, Former Employee or a beneficiary of an Employee or Former Employee who is covered under the Program.

2.08 **"Disability Benefit Claim"** means a claim made in respect of a benefit provided by a Component Welfare Plan, if the Component Welfare Plan conditions its availability to the claimant upon a showing or finding of disability; provided, however, that the term shall not include such a claim if the finding of disability is to be made by a party other than the Program or the Component Welfare Plan for purposes other than making a benefit determination under the Component Welfare Plan.

2.09 **"Employee"** means a regular or temporary employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.10 **"Employer"** means the Company and any Related Employer, to the extent that such Related Employer has adopted one or more of the Component Welfare Plans in accordance with the terms thereof and continues to be a Related Employer thereunder.

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

2.12 **"Former Employee"** means any person formerly employed by an Employer as an Employee or any other person treated under the terms of a Component Welfare Plan as a former employee.

2.13 **"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide (directly or otherwise) "medical care" within the meaning of Section 733(a) of ERISA to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

2.14 **"Group Health Plan Claim"** means a claim made in respect of a benefit provided under a Group Health Plan.

2.15 **"Participant"** means each Employee and Former Employee who satisfies the requirements of Article III of this Program regarding eligibility and participation.

2.16 **"Participant Contribution"** means the pre-tax or after-tax contribution required to be paid by or on behalf of a Participant, if any, as determined under each Component Welfare Plan. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-insured arrangement as well as contributions used to pay premiums under an insurance policy or other arrangement.

2.17 **"Program"** means the NiSource Life and Medical Benefits Program set forth herein, together with any and all amendments and supplements thereto.

2.18 **"Plan Administrator"** means the Committee.

2.19 **"Related Employer"** means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.20 **"Urgent Care Claim"** has the meaning set forth in Section 6.02(b) below.

ARTICLE III
PARTICIPATION

3.01 **Eligibility**. An Employee or Former Employee of an Employer shall become a Participant in the Program when he or she satisfies the eligibility and enrollment requirements of any Component Welfare Plan. A dependent or beneficiary of an Employee or Former Employee may become covered under the Program when he or she satisfies the eligibility and enrollment requirements of any Component Welfare Plan.

3.02 **Termination of Participation**. Participation of a Participant under the Program shall cease when such Participant ceases to participate in any Component Welfare Plan. A dependent or beneficiary of a Participant shall cease to be covered under the Program when he or she ceases to be covered under any Component Welfare Plan.

ARTICLE IV
FUNDING AND BENEFITS

4.01 **Funding**. The terms of each Component Welfare Plan shall govern the amount and timing of any Participant Contributions and any contributions required to be made by the Employer. Nothing herein requires the Employer to contribute to or under any Component Welfare Plan, or to maintain any fund or segregate any amount for the benefit of any Participant or his beneficiary, except to the extent specifically required under the terms of a Component Welfare Plan. No Participant or beneficiary shall have any right to, or interest in, the assets of any Employer.

Different funding mechanisms may be used to provide benefits under any Component Welfare Plan. Such funding mechanisms shall be set out in the policies, contracts or other documents that form part of such Component Welfare Plan.

4.02 **Benefits.** Benefits will be paid solely in the form and in the amount set forth under the Component Welfare Plans.

ARTICLE V
ADMINISTRATION OF PROGRAM

5.01 **Committee to Administer the Program**. The Program shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning

of ERISA. The Committee may delegate its fiduciary responsibilities under the Program to the extent permitted by ERISA.

5.02 **The Committee**. The powers of the Committee are set forth below and in the charter that created the Committee, as such charter may be modified from time to time.

5.03 **Powers of the Plan Administrator.** The Plan Administrator shall have the duties and powers necessary to administer the Program properly, including, but not limited to, the following:

(a) To maintain all Program records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Program, construe Program terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Program;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Program;

(h) To determine the status and rights of all Covered Persons;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Program or any Component Welfare Plan;

(k) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Program;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Program properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Program. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Program.

Notwithstanding the foregoing or any other provision of this Program, to the extent the benefits under any Component Welfare Plan are provided under a fully insured arrangement, the insurance company for such Component Welfare Plan shall have the responsibility for determining entitlement to benefits thereunder and for prescribing the claims procedures to be followed by

Participants and beneficiaries thereunder. The insurance company will act as a named fiduciary with respect to such Component Welfare Plan and this Program and will have the full power to interpret and apply the terms of such Component Welfare Plan as they relate to benefits provided under the applicable insurance policy.

5.04 **Interpretative Authority**. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Program or the interpretation thereof, including, without limitation, the construction of the language of the Program (and of the Component Welfare Plans) and any summary plan descriptions thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Program shall be binding upon all persons dealing with the Program or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Program shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

5.05 **Appointment of Claims Administrators**. The Plan Administrator shall appoint one or more Claims Administrators to provide administrative services to the Plan Administrator in connection with the operation of the Program and the Component Welfare Plans and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons, entity or entities serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

5.06 **Limitation on Liability**. Notwithstanding any of the other provisions of the Program, none of the Company, any Employer, any member of the Committee or any Employee or agent of any Employer, shall be liable to any Participant or any other person for any claim, loss, liability or expense incurred in connection with the Program or the Component Welfare Plans.

ARTICLE VI
CLAIMS FOR BENEFITS

6.01 **Component Welfare Plan Claims Procedures.** Except as otherwise provided in this Section 6.01, a claim for benefits under a Component Welfare Plan shall be submitted to the party designated under, and shall be governed solely by, the claims procedures prescribed under the terms of such Component Welfare Plan and not the claims procedures of this Article VI. In the event, and only in the event, that (i) a Component Welfare Plan does not prescribe claims procedures for benefits that satisfy the requirements of Section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in a particular Component Welfare Plan shall not apply, the claims procedures described below in this Article VI shall apply with respect to such Component Welfare Plan. Notwithstanding the previous sentence, the claims procedures of this Article VI shall not apply with respect to a Component Welfare Plan that is subject to Code Section 9815 or ERISA Section 715.

6.02 Consideration of Initial Claim.

(a) Filing Initial Claim. The Claims Administrator shall process benefit claims pursuant to the procedures set forth below. Except as otherwise provided in a Component Welfare Plan, initial claims shall be filed within three years from the date a charge is incurred.

(b) Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Program. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within 24 hours after receipt of the claim he or she shall be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Claims Administrator shall notify the claimant of its decision regarding the completed claim either within 48 hours of receipt of the missing information, or within 48 hours of the end of the reasonable time period indicated in the notice.

An "Urgent Care Claim" is any Group Health Plan 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 the ability of the patient to regain maximum function, or in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Program. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the initial 15-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within five days after receipt of the claim he or she shall be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Pre-Service Claim" is any Group Health Plan Claim where the Component Welfare Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide notice of an adverse determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Program if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims

Administrator expects to render a decision. With respect to a Group Health Plan Claim, if the claimant does not provide sufficient information for the Claims Administrator to make a determination, the claimant shall receive notice of the specific information necessary to complete the claim. Once the claimant is notified he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Post-Service Claim" is any claim that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

Notwithstanding the foregoing, for Post-Service Claims that are not Group Health Plan Claims or Disability Benefit Claims, a 90-day determination period and a 90-day extension period shall be substituted for the 30-day determination period and 15-day extension period set forth above in this subsection (d).

Notwithstanding the foregoing, for Post-Service Claims that are Disability Benefit Claims, a 45-day determination period and a 30-day extension period shall be substituted for the 30-day determination period and the 15-day extension period set forth above in this subsection (d). In addition, the determination period may be extended for up to an additional 30 days for matters beyond the control of the Program if, prior to the expiration of the initial 30-day extension period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. Any notice of extension with respect to a Disability Benefits Claim 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 the claimant shall be afforded at least 45 days within which to provide the specified information.

(e) Concurrent Care Claims. In the case of an ongoing course of treatment covered under a Group Health Plan, the claimant shall receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Claims Administrator shall notify the claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. The Claims Administrator shall be solely responsible for handling all Concurrent Care Claims.

6.03 If the Claims Administrator Denies the Initial Claim. If the Claims Administrator denies all or any portion of a claim, it shall provide notice of the denial stating (1) the specific reason for the denial; (2) the specific Component Welfare Plan provisions on which the denial is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) a description of the Component Welfare Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, 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 shall be provided to the claimant free of charge, or the claimant shall be informed that

such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 Component Welfare Plan to the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Claims Administrator denies a claimant's Urgent Care Claim in whole or in part, the Claims Administrator shall provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Claims Administrator shall provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

6.04 Appeal to the Claims Administrator.

(a) General. If the Claims Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for review to the Claims Administrator within 180 days of receipt of the Claims Administrator's notice of claim denial. Notwithstanding the foregoing, for claims other than Group Health Claims and Disability Benefit Claims, a written request for review of the denial of all or any portion of such claim must be sent to the Claims Administrator within 60 days of receipt of the Claims Administrator's notice of claim denial.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a request for review, the Claims Administrator shall conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a Group Health Plan Claim or a Disability Benefit Claim, the review shall not afford any deference to the Claims Administrator's adverse benefit determination, and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is subject of the appeal, nor the subordinate of such individual.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, if the denial 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 consultant 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 the claimant the identities of any medical or vocational

experts whose advice was obtained on behalf of the Component Welfare Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Expedited Review for Urgent Care Claims. In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. The Claims Administrator shall notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(d) Post-Service Claims. In the case of a Group Health Plan Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

In the case of a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review, except that such 45-day period may be extended for up to 45 days for special circumstances if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

In the case of a claim other than a Group Health Plan Claim or a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review, except that such 60-day period may be extended for up to 60 days for special circumstances if, prior to the expiration of the initial 60-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

6.05 If the Claims Administrator Denies a Claim on Appeal. If the Claims Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Component Welfare Plan provisions on which the denial is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Component Welfare Plan and a claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 Component Welfare Plan to the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and your State insurance regulatory agency."

6.06 Appeal to the Plan Administrator of Pre- and Post-Service Claim Denials.

(a) General. If the Claims Administrator denies all or any portion of a Pre-Service Claim or a Post-Service Claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of receipt of the Claims Administrator's notice of claim denial. Notwithstanding the foregoing, for claims other than Group Health Claims and Disability Benefit Claims, a written request for review of the denial of all or any portion of such claim on appeal must be sent to the Claims Administrator within 60 days of receipt of the Claims Administrator's notice of claim denial.

Requests for review should be sent to:

NiSource Inc.
801 E. 86th Avenue
Merrillville, Indiana 46410
Attn: ERISA Claims Review
Benefits Administration Department

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a request for review, the Plan Administrator shall conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a Disability Benefits Claims or a Group Health Plan

Claim, the review shall not afford any deference to the Plan Administrator's adverse benefit determination, and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is subject of the appeal, nor the subordinate of such individual.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, if the denial was based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant 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 Plan Administrator shall provide to the claimant the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Pre-Service Claims. In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant 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 a claimant's request for review.

(c) Post-Service Claims. In the case of a Group Health Plan Claim, the Plan Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

In the case of a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review, except that such 45-day period may be extended for up to 45 days for special circumstances if, prior to the expiration of the initial 45-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

In the case of a claim other than a Group Health Plan Claim or a Disability Benefits Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review, except that such 60-day period may be extended for up to 60 days for special circumstances if, prior to the expiration of the initial 60-day period, the Claims Administrator notifies the claimant of the special circumstances requiring the extension and the date by which the Claims Administrator expects to render the determination on review.

6.07 If the Plan Administrator Denies a Claim on Appeal. If the Plan Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Component Welfare Plan and a

claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

With respect to a Disability Benefits Claims or a Group Health Plan Claim, if the Plan 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant upon request. If the Plan 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 Component Welfare Plan to the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and your State insurance regulatory agency."

6.08 **Limitations Upon Civil Actions**. With respect to a claim for benefits under the Program subject to this Article VI, no civil action may be commenced unless the claims procedure process described in this Article VI has been exhausted. In addition, in no event may any civil action regarding such 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.

6.09 **Construction of Section**. This Article shall be construed in a manner consistent with Department of Labor regulations governing claims procedures applicable to "employee welfare benefit plans" within the meaning of Section 3(1) of ERISA.

ARTICLE VII
MISCELLANEOUS PROVISIONS

7.01 **Assignment of Benefits**. Except as required by law, or as expressly provided in a Component Welfare Plan, no benefit payable at any time under the Program shall be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, bankruptcy, or, in any other manner, and no benefit payable under the Program shall be liable for, or subject to, any obligation or liability of any Covered Person. If any Covered Person entitled to a benefit under any Component Welfare Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part, or if by reason of his or her bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her beneficiaries, in a manner the Plan Administrator may deem proper.

7.02 Information To Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Program.

7.03 Limitation of Rights. Neither the establishment of the Program nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

7.04 Program Not Contract. The Program shall not be deemed to constitute a contract between an Employer and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Program shall be deemed to give any Employee the right to be retained in the service of an Employer or to interfere with the right of an Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by an Employer with the bargaining representative of any Employee.

7.05 No Limitation of Management Rights. Participation in the Program shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect an Employer's rights to discipline or terminate an Employee.

7.06 Fiduciary Operation. Each fiduciary with respect to the Program shall discharge his or her duties with respect to the Program solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Program; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Program, except as otherwise required by law.

7.07 No Guaranty. No person shall have any right or interest in the Program other than as specifically provided herein. Except to the extent required by law, no Employer shall be liable for the payment of any benefit provided for herein. All benefits hereunder shall be payable only from the Program, and only to the extent that the Program has been allocated sufficient assets; provided, however, that benefits provided under a Component Welfare Plan that are furnished pursuant to a policy or contract of insurance with an insurance company shall be paid solely by such insurance company.

7.08 Covered Person's Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor a Claims Administrator shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Program and it cannot be made because (1) the current address is incorrect; (2) the Covered Person does not respond to the notice sent to the current address; (3) there are conflicting claims to such payment; or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Program, without interest.

7.09 Right of Recovery. Whenever the Program, for whatever reason, has overpaid the amount of benefits that should have been provided, the Program shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Program

shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization.

7.10 Governing Law and Venue. The Program shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Program by establishing a uniform application of law with respect to the administration of the Program, the provisions of this Section 7.10 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Program shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Program and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

7.11 Severability. In the event any portion of this Program is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Program, and the balance of the Program shall remain in full force and effect.

7.12 Participant Litigation. In any action or proceeding involving the Program, Covered Persons or any other person having or claiming to have an interest in the Program shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Program. To the extent permitted by law, if a legal action is begun against the Company, an Employer or other organization or institution providing benefits under the Program by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company, the Employer or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Program shall constitute a release of the Company, each Employer and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

7.13 Counterparts. This Program document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

7.14 Conflict Between Program and Component Welfare Plan. In the event that the provisions of any Component Welfare Plan conflict with the provisions of this document or any other Component Welfare Plan, the Plan Administrator shall, in its discretion, interpret the terms and purpose of the Program so as to resolve any conflict. However, the terms of this document may not increase the rights of a Participant or his beneficiary to benefits available under any Component Welfare Plan.

7.15 Notice. Any notice given under this Program shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to a Claims Administrator, when addressed to it at its home office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Claims Administrator.

7.16 **Extension of Program to Related Employers**. Any Related Employer may adopt one or more of the Component Welfare Plans in accordance with the terms thereof and thereby qualify its Employees and Former Employees to become Participants thereunder and under this Program. A Related Employer that adopts one or more Component Welfare Plans agrees that the Committee shall have the sole right to amend or terminate this Program and that the Committee shall act as the agent for such Related Employer for all purposes of administration of the Program. A Related Employer shall cease to be an Employer under this Program when it is no longer an "Employer" under the terms of any Component Welfare Plan or when all Component Welfare Plans have otherwise terminated with respect to such Related Employer.

7.17 **Construction**. The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Program, nor in any way shall affect the Program or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

ARTICLE VIII
AMENDMENT AND TERMINATION OF THE PLAN

8.01 **Amendment**. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Program. Unless expressly provided otherwise, no amendment shall affect, or be construed to affect, any existing delegations to amend the Program. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of plan assets of the Program to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration.

8.02 **Termination**. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Program for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Program and the Committee may terminate the Program in whole or in part at any time, in each case without liability for such discontinuance or termination.

8.03 **Collective Bargaining Agreement.** Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Program shall be subject to the express terms of any applicable collective bargaining agreement.

[The remainder of this page is intentionally left blank.]

IN WITNESS WHEREOF, the Committee has caused this Program to be executed on its behalf, by one of its members duly authorized, this 12th day of June, 2015, to be effective as of January 1, 2015.

NISOURCE BENEFITS COMMITTEE

By: _____

Its: VP, HR
Committee Member

EXHIBIT A
COMPONENT WELFARE PLANS

NiSource Consolidated Flex Medical Plan

NiSource Life Insurance Plan

NISOURCE DENTAL PLAN

As Amended and Restated
Effective as of January 1, 2016

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Plan 1
1.02 Plan Components 1

ARTICLE II DEFINITIONS 1
2.01 "Adopted Child" 1
2.02 "Annual Enrollment Period" 1
2.03 "Category of Coverage" 1
2.04 "Child" 1
2.05 "Claims Administrator" 1
2.06 "COBRA" 1
2.07 "COBRA Continuation Coverage" 1
2.08 "Code" 2
2.09 "Columbia Divested Company" 2
2.10 "Committee" 2
2.11 "Company" 2
2.12 "Coverage Option" 2
2.13 "Covered Employee" 2
2.14 "Covered Expense" 2
2.15 "Covered Percentage" 2
2.16 "Covered Person" 2
2.17 "Covered Person Contribution" 2
2.18 "Covered Same-Sex Domestic Partner" 2
2.19 "CPG" 2
2.20 "CPG Related Employer" 2
2.21 "CPG Spin-Off" 2
2.22 "Dental Plan Option" 2
2.23 "Dental Plus Option" 2
2.24 "Deductible" 2
2.25 "Dentist" 3
2.26 "Dependent" 3
2.27 "Employee" 4
2.28 "Employer" 4
2.29 "ERISA" 4
2.30 "Family" 4
2.31 "Financially Interdependent" 4
2.32 "Flexible Benefits Plan" 4
2.33 "FMLA" 5
2.34 "Foster Child" 5
2.35 "Full-Time Employee" 5
2.36 "Group Health Plan" 5
2.37 "HIPAA" 5
2.38 "Injury" 5
2.39 "Legal Ward" 5
2.40 "Maximum Reimbursable Charge" 5
2.41 "Medically Necessary" 5
2.42 "Medicare" 5

2.43 "NIPSCO" 5
2.44 "No Coverage Option" 5
2.45 "Other Party" 5
2.46 "Part-Time Employee" 6
2.47 "Participant" 6
2.48 "Physician" 6
2.49 "Plan" 6
2.50 "Plan Administrator" 6
2.51 "Plan Year" 6
2.52 "Preventive Dental Option" 6
2.53 "Qualified Beneficiary" 6
2.54 "Qualifying Event" 7
2.55 "Related Employer" 7
2.56 "Represented" 7
2.57 "Same-Sex Domestic Partner" 7
2.58 "Separation Date" 8
2.59 "Sickness" 8
2.60 "Spouse" 8
2.61 "Springfield Operating Represented Employee" 8
2.62 "Springfield Clerical/Technical Represented Employee" 8
2.63 "Status Change" 8
2.64 "Stepchild" 9
2.65 "Summary Plan Description" 9

ARTICLE III PARTICIPATION 9
3.01 Eligibility 9
3.02 Enrollment 10
3.03 Categories of Coverage 12
3.04 Opt-Out Credit 12
3.05 Election of a Category of Coverage 12
3.06 Election of a Coverage Option 12

ARTICLE IV PREVENTIVE DENTAL OPTION 13
4.01 Eligibility 13
4.02 Schedule of Benefits 13
4.03 Deductible 13

ARTICLE V DENTAL PLAN OPTION 14
5.01 Eligibility 14
5.02 Schedule of Benefits 14
5.03 Deductible 14

ARTICLE VI DENTAL PLUS OPTION 14
6.01 Eligibility 14
6.02 Schedule of Benefits 14

ARTICLE VII CONTRIBUTIONS TO THE PLAN 15
7.01 Covered Person Contributions 15
7.02 Employer Contributions 15

ARTICLE VIII DENTAL BENEFITS 15
8.01 General 15

8.02 Preventive Treatment 15
8.03 Basic Treatment 16
8.04 Major Treatment 16
8.05 Orthodontia 17

ARTICLE IX GENERAL EXCLUSIONS 18

ARTICLE X SUBROGATION 20
10.01 Subrogation 20
10.02 Right of Recovery 20
10.03 Application to Funds Recovered 20
10.04 Cooperation Required 20
10.05 First Lien Created 21
10.06 Constructive Trust 21
10.07 Personal Liability Created 21

ARTICLE XI NONDUPLICATION OF BENEFITS 22
11.01 General 22
11.02 Definitions 22
11.03 Application of the Rules 22
11.04 Plan as Primary Payor 23
11.05 Plan as Secondary Payor 23
11.06 When Other Plan Has No Nonduplication of Benefits Rules 23
11.07 Vehicle Coverage Limitation 23
11.08 If Medicare Is Involved 23

ARTICLE XII ADMINISTRATION OF PLAN 26
12.01 Committee to Administer the Plan 26
12.02 The Committee 26
12.03 Powers of the Plan Administrator 26
12.04 Interpretative Authority 26
12.05 Appointment of the Claims Administrator 27

ARTICLE XIII CLAIMS FOR BENEFITS 27
13.01 Consideration of Initial Claim 27
13.02 If the Claims Administrator Makes an Adverse Benefit Determination Regarding the Initial Claim 29
13.03 Mandatory First-Level Internal Appeal to the Claims Administrator 29
13.04 If the Claims Administrator Makes an Adverse Benefit Determination on a Mandatory First-Level Internal Appeal 31
13.05 Mandatory Second-Level Internal Appeal to the Claims Administrator of Pre-and Post-Service Claim Denials. 31
13.06 If the Claims Administrator Makes an Adverse Benefit Determination on a Mandatory Second-Level Internal Appeal 32
13.07 Limitations Upon Civil Actions 33
13.08 Construction of Section 33

ARTICLE XIV TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE 33
14.01 Cessation of Participation 33
14.02 Leave of Absence Under the FMLA 34
14.03 Military Leave Policy 34
14.04 Severance 34

14.05 COBRA 34

ARTICLE XV PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION 37
15.01 General 37
15.02 Permitted Uses and Disclosure 37
15.03 Disclosures to Company 37
15.04 Adequate Separation 38
15.05 Unauthorized Use or Disclosure 38
15.06 Special Amendatory Authority 39

ARTICLE XVI PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION 39
16.01 General 39
16.02 Duty of the Plan Sponsor 39

ARTICLE XVII MISCELLANEOUS PROVISIONS 39
17.01 Assignment of Benefits 39
17.02 Information To Be Furnished 40
17.03 Limitation of Rights 40
17.04 Plan Not Contract 40
17.05 Fiduciary Operation 40
17.06 No Guaranty 40
17.07 Misrepresentation 41
17.08 Inadvertent Error 41
17.09 No Limitation of Management Rights 41
17.10 No Liability for Acts of Any Provider 41
17.11 Covered Person's Responsibilities 41
17.12 Right of Recovery 41
17.13 Governing Law and Venue 41
17.14 Severability 42
17.15 Participant Litigation 42
17.16 Counterparts 42
17.17 Notice 42
17.18 Extension of Plan to Related Employers 42

ARTICLE XVIII FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 43
18.01 Plan Self-Insured 43
18.02 Participants' and Dependents' Rights Unsecured 43
18.03 Amendment 43
18.04 Termination 43
18.05 Collective Bargaining Agreement 43

ARTICLE I
INTRODUCTION

1.01 Purpose of Plan. Columbia Energy Group established and maintained the Columbia Energy Group Dental Plan to provide group dental benefits for the participants and beneficiaries thereunder. The Columbia Energy Group Dental Plan was broadened to include coverage for the former participants and beneficiaries of other dental plans sponsored by NiSource Inc. (the "Company") or an affiliate, was renamed the NiSource Dental Plan, effective as of January 1, 2004, and as of such date, was sponsored and maintained by the Company. The Plan was amended and restated, effective January 1, 2006, to reflect the adoption of a new dental plan option and other modifications to the Plan. The Plan was further amended and restated effective January 1, 2008, January 1, 2011, January 1, 2013, January 1, 2014, January 1, 2015 and July 1, 2015. This is an amended and restated version of the Plan, effective as of January 1, 2016, that reflects certain plan design changes.

1.02 Plan Components. The Plan has three components: Preventive Dental, Dental Plan and Dental Plus. Alternatively, an Employee may choose the No Coverage Option.

ARTICLE II
DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

2.01 **"Adopted Child"** means any child legally adopted by, or placed for adoption with, a Participant or Covered Same-Sex Domestic Partner.

2.02 **"Annual Enrollment Period"** means the period selected by the Company each year during which time an Employee may select a Coverage Option to be effective for the following Plan Year.

2.03 **"Category of Coverage"** means each of the coverage choices described in Section 3.03.

2.04 **"Child"** means a person who is either (1) a naturally born child of a Participant; (2) an Adopted Child; (3) a Stepchild; (4) a Foster Child; (5) a Legal Ward who is dependent upon a Participant or Covered Same-Sex Domestic Partner for at least 50% of his or her financial support and who may be claimed the income tax return of the Participant or Covered Same-Sex Domestic Partner as a dependent (without giving effect to the Legal Ward's gross income); or (6) any person deemed by court order to be a Child for purposes of the Plan.

2.05 **"Claims Administrator"** means the person, persons or entity appointed by the Plan Administrator to process benefit claims pursuant to Section 12.05.

2.06 **"COBRA"** means Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.07 **"COBRA Continuation Coverage"** means continuation coverage to the extent required by COBRA.

2.08 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.09 **"Columbia Divested Company"** means any one of the following companies that previously was affiliated with a Related Employer: Columbia Energy Services Corp., Columbia Propane Corporation, Columbia Electric Corporation, Columbia LNG Corporation, Energy.com Corporation, Columbia Trans Communications, Commonwealth Propane, Columbia Propane LP, Columbia Petroleum Corporation, Columbia Natural Resources Inc., Hawg Hauling & Disposal Inc., Coal Gas, CS-42, Gas Development, New York Gas & Elec, Pittsburgh Market Division and Columbia Gas of West Virginia.

2.10 **"Committee"** means the NiSource Benefits Committee or its predecessor, the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

2.11 **"Company"** means NiSource Inc., a Delaware corporation.

2.12 **"Coverage Option"** means the Preventive Dental Option, Dental Plan Option, Dental Plus Option, or the No Coverage Option.

2.13 **"Covered Employee"** means an individual who is (or was) provided coverage under the Plan by virtue of the performance of services by the individual for an Employer.

2.14 **"Covered Expense"** means a service or supply, the Covered Percentage of which is paid for by the Plan, or which is subject to an applicable Deductible.

2.15 **"Covered Percentage"** means the percentage of a Covered Expense covered by the Plan.

2.16 **"Covered Person"** means an Employee or Dependent covered under the Plan, and includes a Qualified Beneficiary covered under the Plan.

2.17 **"Covered Person Contribution"** means the contribution required under Section 7.01.

2.18 **"Covered Same-Sex Domestic Partner"** means a Same-Sex Domestic Partner covered under the Plan.

2.19 **"CPG"** means Columbia Pipeline Group, Inc., a Delaware corporation.

2.20 **"CPG Related Employer"** means, on and after the Separation Date, (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes CPG; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with CPG; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes CPG.

2.21 **"CPG Spin-Off"** means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG.

2.22 **"Dental Plan Option"** means the Dental Plan Option described in Article V.

2.23 **"Dental Plus Option"** means the Dental Plus Option described in Article VI.

2.24 **"Deductible"** means the amount that must be incurred by a Covered Person in a Plan Year before the Plan will pay benefits.

2.25 **"Dentist"** means a doctor legally qualified and licensed in the care, treatment and replacement of teeth.

2.26 **"Dependent"** means:

(a) The Spouse of a Participant, if not legally separated;

(b) The Same-Sex Domestic Partner of a Participant;

(c) A Child who has not attained 26 years of age;

(d) An unmarried Child who satisfies the "dependency test" described in this Section 2.22 and who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the Child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date Dependent status would otherwise terminate and is provided to the Claims Administrator every three years thereafter, or more frequently if requested by the Claims Administrator; (2) the Child is dependent upon the Participant (or Covered Same-Sex Domestic Partner of the Participant, as the case may be) for financial support and maintenance; (3) the Employee continues to be covered by the Plan; and (4) the Child's disability continues; or

(e) A Child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient under ERISA, as having a right to participate in the Plan as a Dependent.

For purposes of this Section 2.26, a Child of a Participant or of a Covered Same-Sex Domestic Partner satisfies the "dependency test" for a particular Plan Year if

(x) the Participant or the Covered Same-Sex Domestic Partner would be allowed a dependent exemption for such Child in computing his or her federal taxable income for such Plan Year, or

(y) each of the following conditions is satisfied: (1) such Child receives over half of his or her support during the Plan Year from his or her parents and is in the custody of one or both parents for more than half of the Plan 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 Plan 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 month of the Plan Year.

For purposes of the "dependency test" in clause (x) above, the Child's gross income for such Plan Year may be ignored in determining whether the Participant or Covered Same-Sex Domestic Partner would be entitled to a dependent exemption for such Child for such Plan Year.

Notwithstanding any other provision of the Plan, but subject to the provisions of Section 14.05(h), regarding COBRA-like continuation coverage for a Covered Person under the circumstances described therein, provided the Covered Person was entitled to such coverage immediately prior to January 1, 2017, effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child shall be a Dependent eligible for coverage, or entitled to any benefits, under the Plan.

2.27 **"Employee"** means a regular or temporary employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common-law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.28 **"Employer"** means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that a group health plan providing dental benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.28, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

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

2.30 **"Family"** means a Participant and such Participant's covered Dependents.

2.31 **"Financially Interdependent"** means that a Participant and another person satisfy any two of the following conditions:

(a) the Participant designates such other person as the Participant's beneficiary for employer-sponsored retirement or life insurance benefits;

(b) the Participant designates such other person as the primary beneficiary under the Participant's will;

(c) the Participant designates such other person as the Participant's attorney-in-fact under a durable power of attorney for health care;

(d) the Participant and such other person have a common ownership or leasehold interest in real property;

(e) the Participant and such other person have joint bank or credit accounts or joint investments; or

(f) the Participant and such other person have joint liability for a mortgage, lease or loan.

2.32 **"Flexible Benefits Plan"** means the NiSource Flexible Benefits Plan, as amended or restated from time to time.

2.33 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

2.34 **"Foster Child"** means a child legally placed in the custody of a Participant or Covered Same-Sex Domestic Partner by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, who is receiving parental care from such Participant Covered Same-Sex Domestic Partner, and for whom such Participant or Covered Same-Sex Domestic Partner is legally responsible to provide medical care.

2.35 **"Full-Time Employee"** means an Employee characterized by an Employer as a full-time employee who regularly works 40 or more hours per week or, with respect to a Represented Employee, who regularly works such other period of time that is specified in the collective bargaining agreement covering such Employee as constituting full-time status for purposes of the Plan.

2.36 **"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

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

2.38 **"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 a Covered Person's body from an external force or contact.

2.39 **"Legal Ward"** means any Child for whom a Participant or Covered Same-Sex Domestic Partner is legal guardian, provided that such Child is dependent on such Participant or Covered Same-Sex Domestic Partner for principal support and maintenance.

2.40 **"Maximum Reimbursable Charge"** means the maximum amount of charges that the Plan will pay for a service, treatment or supply. The determination of the Maximum Reimbursable Charge shall be made by the Claims Administrator or Plan Administrator, in their sole discretion, based on criteria agreed upon by the Company and the Claims Administrator or Plan Administrator, as applicable.

2.41 **"Medically Necessary"** means a service or supply ordered or prescribed by a Physician 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 the Covered Person's health status to result in information that could affect treatment, if a diagnostic procedure; and (3) no more costly than any alternative.

2.42 **"Medicare"** means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended.

2.43 **"NIPSCO"** means Northern Indiana Public Service Company.

2.44 **"No Coverage Option"** means an Employee's election not to become covered under a Coverage Option.

2.45 **"Other Party"** includes, without limitation, any of the following:

(a) Any party or parties who cause a Sickness or Injury;

(b) Any insurer or other indemnifier of the party or parties who caused a Sickness or Injury;

(c) Any guarantor of the party or parties who cause a Sickness or Injury;

(d) A Covered Person's insurer;

(e) A workers' compensation insurer; or

(f) Any other person, entity, policy or plan that is liable or legally responsible in relation to a Covered Person's Sickness or Injury.

2.46 **"Part-Time Employee"** means an Employee characterized by an Employer as a part-time employee who regularly works less than 40 hours per week or, with respect to a Represented Employee, who regularly works such other period of time that is specified in the collective bargaining agreement covering such Employee as constituting part-time status for purposes of the Plan.

2.47 **"Participant"** means each Employee who is a Covered Person.

2.48 **"Physician"** means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. 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 Physicians 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 the Plan shall be deemed to be a Physician.

2.49 **"Plan"** means the NiSource Dental Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.51 **"Plan Year"** means the calendar year.

2.52 **"Preventive Dental Option"** means the Preventive Dental Option described in Article IV.

2.53 **"Qualified Beneficiary"** means:

(a) Any persons who were Covered Persons on the date immediately preceding a Qualifying Event as:

(1) An Employee;

(2) An Employee's Spouse; or

(3) A Dependent Child.

(b) A Child who is born to or placed for adoption with a Covered Employee who is a Qualified Beneficiary during a period of COBRA Continuation Coverage. The COBRA Continuation Coverage period for such a Qualified Beneficiary shall run from his or her birth or adoption to the end of the COBRA Coverage period for all Qualified Beneficiaries entitled to COBRA coverage as a result of the same Qualifying Event.

2.54 **"Qualifying Event"** means any of the following that results in loss of coverage for a Qualified Beneficiary:

(a) The Covered Employee's employment ends (except in the case of gross misconduct);

(b) The Covered Employee's work hours are reduced;

(c) The Covered Employee becomes entitled to benefits under Medicare;

(d) The Covered Employee's death;

(e) The divorce or legal separation of the Covered Employee from the Covered Employee's Spouse; or

(f) A Dependent Child is no longer an eligible Dependent.

2.55 **"Related Employer"** means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.56 **"Represented"** means a Full-Time or Part-Time Employee who is covered by a collective bargaining agreement between an Employer and a union.

2.57 **"Same-Sex Domestic Partner"** means, with respect to a Participant, a person of the same sex as the Participant, if the Participant and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is the Participant's registered domestic partner, or is a party to a civil union with the Participant, under the laws of the Participant's state of residence; or

(b) The Participant and such person

(1) are both age 18 or older and competent to enter into a legal contract;

(2) have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are Financially Interdependent;

(3) share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in the Participant's state of residence;

(4) reside in a state that, prior to June 26, 2015, did not recognize or permit same-sex marriage, domestic partner registration or civil union;

(5) are not currently married to, a party to a civil union with, or the domestic partner, of any other person;

(6) intend that their same-sex domestic partnership be of unlimited duration; and

(7) do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

From time to time, a Participant may be required to confirm orally, electronically or in writing, in a manner prescribed by the Plan Administrator, that the Participant and his or her Same-Sex Domestic Partner satisfy the foregoing eligibility requirements.

2.58 **"Separation Date"** means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

2.59 **"Sickness"** means an illness causing loss commencing while the Plan is in force for a Covered Person. 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 Physician.

2.60 **"Spouse"** means a person who is treated as a spouse under the Code.

2.61 **"Springfield Operating Represented Employee"** means an Employee of Bay State Gas Company represented by the United Steel Workers Local Union No. 12026 (Springfield Operating).

2.62 **"Springfield Clerical/Technical Represented Employee"** means an Employee of Bay State Gas Company represented by the United Steel Workers Local Union No. 12026 (Springfield Clerical/Technical).

2.63 **"Status Change"** means any of the following:

(a) Legal Marital Status. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(b) Number of Dependents. Events that change an Employee's number of Dependents, including birth, adoption, placement for adoption (as defined in Treasury Regulations under Code Section 9801), or death of a Dependent.

(c) Employment Status. A termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite that changes the employment status of an Employee, a Spouse or other Dependent, or any other change in the employment status of an Employee, a Spouse or other Dependent that makes such individual eligible or ineligible for coverage under the Plan (such as switching from full-time to part-time status or from salaried to hourly-paid).

(d) Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the Plan.

(e) Residence. A change in the place of residence of an Employee, a Spouse or other Dependent.

(f) Other Permissible Events. Any other event that the Plan Administrator or a member of the Committee determines to be a permissible Status Change under the Code or any regulation, ruling or release issued thereunder. Such determination shall be (1) consistent with the terms of the Plan; and (2) made in a uniform and non-discriminatory manner.

As used in this Section 2.63, and subject to the immediately following paragraph, the term "Dependent" shall include only those Dependents described in Section 2.26 above who would be considered a "dependent" for purposes of Code Section 125, the regulations thereunder, and Internal Revenue Service Notice 2010-38, as such statutory provision, regulations or guidance may be amended or modified from time to time.

Solely for purposes of this Section 2.63 and Section 3.02(c), and only for the period beginning January 1, 2013, and ending on December 31, 2016, a "Spouse" will be deemed to include a Participant's Same-Sex Domestic Partner, "marriage" will be deemed to include the establishment of a Same-Sex Domestic Partner relationship, "divorce" will be deemed to include the termination of a Same-Sex Domestic Partner relationship, and the term "Dependent" will be deemed to include a Same-Sex Domestic Partner and a Same-Sex Domestic Partner's Child; provided, however, that notwithstanding any other provision of the Plan, no Category of Coverage change under Section 3.02(c) involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee, in their sole discretion.

2.64 **"Stepchild"** means any natural or adopted child of a Participant's current Spouse or Same-Sex Domestic Partner, and any natural or adopted child of a former Spouse or Same-Sex Domestic Partner of a Participant living in the Participant's home in a familial relationship if the natural parents of such child are both deceased.

2.65 **"Summary Plan Description"** means the summary plan description for the Plan.

ARTICLE III
PARTICIPATION

3.01 **Eligibility**. Subject to the specific eligibility restrictions provided for each Coverage Option described in Articles IV, V and VI, Employees shall be eligible to participate in the Plan as follows:

(a) Regular Employees. Each regular, Full-Time and Part-Time Employee of an Employer may be covered under the Plan on the first day of his or her active employment, provided he or she properly enrolls for coverage under Section 3.02; provided, however, that Part-Time Springfield Operating Represented Employees shall not be eligible for coverage under the Plan. For new hires, such Employee must be actively at work on the date coverage is scheduled to begin.

(b) Temporary Employees. Each eligible Employee characterized by an Employer as a temporary employee may be covered under the Plan.

(c) Dependents. An eligible Dependent of a Participant who is properly enrolled for coverage under Section 3.02 shall be covered on the earliest of (1) January 1 after the Annual Enrollment Period in which a Participant elects to cover such Dependent; (2) with respect to the Dependent of a Participant hired after January 1, the date the Participant's

coverage becomes effective; or (3) the date coverage is provided under the provisions of subsections 3.02(c)-(h).

(d) No Double Coverage. Notwithstanding the foregoing, no person is eligible to be covered as both a Participant and a Dependent, nor may any person be covered as a Dependent of more than one Covered Person.

3.02 Enrollment. Subject to the specific eligibility restrictions provided for each Coverage Option described in Articles IV, V and VI, Employees shall be eligible to enroll in the Plan as follows

(a) New Hires. Each newly hired Employee who becomes eligible to become covered under subsection 3.01(a) or (b) shall be permitted to enroll such Employee and any Dependents such Employee desires to cover on or before the day the Employee first becomes eligible for coverage. Any enrollment will be effective for the period beginning on the first day of eligibility and ending on the last day of the Plan Year in which such participation begins. If a newly hired Employee fails to properly enroll, he or she shall be covered pursuant to Sections 3.05 and 3.06.

(b) Annual Enrollment Period. An eligible Employee or Qualified Beneficiary may elect or change any Coverage Option during the Annual Enrollment Period. Such election shall be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year; provided, however, if such Employee or Qualified Beneficiary makes no election or change during the Annual Enrollment Period, such Employee or Qualified Beneficiary shall be deemed to have elected to continue his or her existing Coverage Option for the following Plan Year.

(c) Status Change Enrollment. If a Status Change occurs, an Employee may make a Category of Coverage change during the Status Change Enrollment Period provided under this subsection; provided, however, if required by Section 125 of the Code and the Regulations, rulings and releases issued thereunder, such Category of Coverage change shall be consistent with the Status Change event. A Category of Coverage change is consistent with a Status Change event if, and only if, (1) the Status Change results in an Employee or Dependent gaining or losing eligibility for coverage under either the Plan or a dental plan of the Dependent's employer; and (2) the Category of Coverage change corresponds with such gain or loss of coverage.

Such Status Change Enrollment Period shall begin on the date of the Status Change event, and shall expire 31 days thereafter. Accordingly, to obtain or modify coverage under this subsection, the Employee shall properly modify his or her enrollment during such Status Change Enrollment Period. Any Category of Coverage change under this subsection shall be effective as of the date it is approved by the Plan.

(d) Judgment, Decree or Order. An Employee may make a Category of Coverage change upon entry of a court judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in Section 609 of ERISA) that requires Plan coverage for a Child.

(e) Entitlement to Medicare or Medicaid. An Employee may make a Category of Coverage change if a Covered Person becomes enrolled under Medicare Parts A, B or C, or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). Any such

Category of Coverage change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan.

(f) Automatic Cost Change. If the cost of the Plan increases or decreases during a Plan Year, a Participant is required to make a corresponding change in his or her payments under the Plan. In such event, on a prospective basis, the Plan Administrator shall automatically effectuate the increase or decrease in the Participant's elective Covered Person Contributions. In addition, the Plan Administrator may automatically make a prospective decrease in a Participant's elective Covered Person Contributions as a result of any event that causes the Participant to lose eligibility for coverage.

(g) Significant Cost Change. An Employee may make a Coverage Option change if the cost of a Coverage Option under the Plan significantly increases or decreases during a Plan Year. Any Coverage Option change must correspond with such increase or decrease in cost. Changes that are permitted include commencing participation in a Coverage Option that significantly decreases in cost, or, in the case of an Coverage Option that significantly increases in cost, revoking an election for that Coverage Option and, in lieu thereof, either receiving on a prospective basis coverage under another Coverage Option providing similar coverage or dropping the Coverage Option if no other Coverage Option providing similar coverage is available. Any such Coverage Option change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan.

(h) Significant Coverage Change. An Employee may make a Coverage Option change:

(1) If the coverage under a Coverage Option is significantly curtailed during a period of coverage, in which case the Participant may revoke his or her election for coverage under such Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Coverage Option providing similar coverage;

(2) If the coverage under a Coverage Option ceases during a period of coverage, in which case the Participant may revoke his or her election for coverage under such Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Coverage Option providing similar coverage, or elect the No Coverage Option if no Coverage Option providing similar coverage is available;

(3) If the Plan adds a new benefit or other coverage option or the terms of a benefit offered under the Plan are significantly improved during a period of coverage; or

(4) On account of and corresponding with a change made under another employer's plan if (i) the other cafeteria plan or qualified benefits plan permits participants to make an election that is consistent with the permitted election change rules under Section 125 of the Code and the regulations issued thereunder, or (ii) the Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the other employer's cafeteria plan or qualified benefits plan.

Any such Coverage Option change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan.

(i) Changes Involving Same-Sex Domestic Partners. Notwithstanding any provision of this Section 3.02, no Category of Coverage change, Coverage Option change, or change in Covered Person Contributions in respect of an event involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or of any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee in their sole discretion.

(j) Enrollment of Same-Sex Domestic Partners and Their Children. Effective January 1, 2017, no Employee may enroll a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's child for coverage under the Plan.

3.03 Categories of Coverage. The Plan offers the following Categories of Coverage:

(a) Employee-Only;

(b) Employee + Spouse;

(c) Employee + Child;

(d) Employee + Family; and

(e) No Coverage.

Where applicable, Categories of Coverage include an eligible Same-Sex Domestic Partner and an eligible Child of a Same-Sex Domestic Partner.

3.04 Opt-Out Credit. An Employee who elects the No Coverage Option under the Plan for himself or herself and his or her Dependents shall receive an Opt-Out Credit (of an amount determined by the Plan Administrator) on a monthly basis (unless otherwise agreed pursuant to an applicable collective bargaining agreement) until he or she ceases to be eligible to participate in the Plan. Notwithstanding anything contained herein to the contrary, (i) a Part-Time Employee shall not be eligible for an Opt-Out Credit; and (ii) an Employee who elects the No Coverage Option under the Plan for himself or herself, but who is covered under the Plan as a Dependent, is not entitled to an Opt-Out Credit.

3.05 Election of a Category of Coverage. An Employee or Qualified Beneficiary may select or change a Category of Coverage during the enrollment periods set forth in Section 3.02 and subject to any requirements or limitations under the Flexible Benefits Plan. A Category of Coverage selection shall remain effective until properly changed during an Annual Enrollment Period or by reason of an event described in subsections 3.02(c)-(h). If a new hire fails to properly enroll, such new hire shall be deemed to have selected Employee-Only coverage.

3.06 Election of a Coverage Option. An Employee may select a Coverage Option as a new hire or during the Annual Enrollment Period. Such an Option selection shall remain effective until properly changed during an Annual Enrollment Period.

(a) If a newly hired Employee fails to properly enroll for coverage, such Employee shall be deemed to have selected the following Coverage Options:

(1) NIPSCO Represented Employees and Springfield Operating Represented Employees shall have been deemed to have selected the Dental Plan Option.

(2) All other Employees shall be deemed to have selected the Preventive Dental Option.

(b) If an Employee fails to properly enroll for coverage during the Annual Enrollment Period, such Employee shall be deemed to have selected the same Coverage Option in place at the beginning of the Annual Enrollment Period:

ARTICLE IV
PREVENTIVE DENTAL OPTION

4.01 Eligibility. The Preventive Dental Option shall be available to all eligible Employees and Dependents as described in Article III, except Northern Indiana Public Service Company Represented Employees.

4.02 Schedule of Benefits.

(a) Covered Person Contributions.

As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company. The Covered Person contribution shall equal the cost of Plan coverage less any Employer contribution.

(b) Covered Percentages.

Type of Care	Covered Percentage
Preventive Care	100%
Basic Services	50% after Deductible
Major Services (other than oral surgery or anesthesia)	Not Covered
Major Services (oral surgery or anesthesia)	50% after Deductible
Orthodontic Services	Not Covered

(c) Plan Year Deductible.

Category of Coverage	Deductible
Employee-Only	$75
Employee + Spouse	$75 per Covered Person up to $150
Employee + Child	$75 per Covered Person up to $225
Employee + Family	$225

(d) Annual Maximum.

Benefits under the Preventive Dental Option are subject to a Plan Year maximum of $2,000 per Covered Person.

4.03 Deductible. The Deductible applies separately to each Covered Person each Plan Year. The Deductible shall be considered met by the Participant and all covered Dependents for the Plan Year in accordance with the above Schedule.

ARTICLE V
DENTAL PLAN OPTION

5.01 Eligibility. The Dental Plan Option shall be available to all eligible Employees and Dependents as described in Article III.

5.02 Schedule of Benefits.

(a) Covered Person Contribution.

As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company. The Covered Person contribution shall equal the cost of Plan coverage less any Employer contribution.

(b) Covered Percentages.

Type of Care	Covered Percentage
Preventive Care	100%
Basic Services	80% after deductible
Major Services (other than oral surgery or anesthesia)	50% after deductible
Major Services (oral surgery or anesthesia)	80% after deductible
Orthodontic Services	Not Covered

(c) Plan Year Deductible.

Category of Coverage	Deductible
Employee-Only	$50
Employee + Spouse	$50 per Covered Person up to $100
Employee + Child	$50 per Covered Person up to $150
Employee + Family	$150

5.03 Deductible. The Deductible applies separately to each Covered Person each Plan Year. The Deductible shall be considered met by the Participant and all covered Dependents for the Plan Year in accordance with the above Schedule.

ARTICLE VI
DENTAL PLUS OPTION

6.01 Eligibility. The Dental Plus Option shall be available to all eligible Employees and Dependents as described in Article III.

6.02 Schedule of Benefits.

(a) Covered Person Contributions.

As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company. The Covered Person contribution shall equal the cost of Plan coverage less any Employer contribution.

(b) Covered Percentages.

Type of Care	Covered Percentage
Preventive Care	100%
Basic Services	80%
Major Services (other than oral surgery or anesthesia)	50%
Major Services (oral surgery or anesthesia)	80%
Orthodontic Services	50% (up to $1,500 lifetime maximum)

(c) Plan Year Deductible. The Dental Plus Option has no Plan Year Deductible.

(d) Plan Year Maximum. The Dental Plus Option has a Plan Year maximum of $2,000 per Covered Person

(e) Plan Year Maximum for Implants. The Dental Plus Option has a separate Plan Year maximum of $600 per Covered Person for implants.

ARTICLE VII
CONTRIBUTIONS TO THE PLAN

7.01 Covered Person Contributions. As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company or Plan Administrator. The Covered Person contribution shall equal the cost of Plan coverage less any Employer contribution.

7.02 Employer Contributions. Except as provided in subsection 14.05(f), each Employer will contribute to the cost of the Plan. The amount of the Employer contribution shall be determined by the Company or Plan Administrator on an annual basis or as otherwise required by a collective bargaining agreement.

ARTICLE VIII
DENTAL BENEFITS

8.01 General. Subject to the provisions of Articles IV, V and VI, as applicable, any Deductible requirements, any Plan Year or lifetime maximums, and any limitations with respect to Maximum Reimbursable Charges, dental benefits under the Plan shall include, but shall not be limited to, dental benefits set forth in this Article. With respect to any Covered Expense incurred at an out-of-network provider, the Plan will pay only an amount equal to the product of the applicable Covered Percentage multiplied by the Maximum Reimbursable Charge for such Covered Expense, after the application of any Deductible.

8.02 Preventive Treatment. Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

(a) Oral examination;

(b) Prophylaxis (cleaning and scaling of teeth);

(c) Periodontal maintenance procedures (following active therapy) and periodontal prophylaxis;

(d) Bite-wing x-rays; and

(e) Topical application of fluoride solutions.

The services described above are each limited to twice in a calendar year.

(f) Topical application of sealant on a posterior tooth for covered persons under age 19 (only one treatment per tooth in any 3 consecutive calendar years);

(g) Panoramic (Panorex) x-ray once in any three consecutive calendar years;

(h) Full-mouth series of x-rays once in any three consecutive calendar years; and

(i) Space maintainers, fixed unilateral – limited to nonorthodontic treatment.

8.03 Basic Treatment. Basic Treatment is designed to correct dental disease, defect or injury and includes:

(a) Routine extractions;

(b) Amalgam and composite/resin restorations;

(c) Root canal therapy (any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service);

(d) Osseous surgery (flap entry and closure is part of the allowance for osseous surgery and not a separate dental service);

(e) Periodontal scaling and root planing – entire mouth;

(f) Adjustments – complete denture (any adjustment of or repair to a denture within six months of its installation is not a separate dental service)

(g) Recementing of bridge;

(h) Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, including (i) removal of impacted tooth, soft tissue, (ii) removal of impacted tooth, partially bony, and (iii) removal of impacted tooth, completely bony;

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed, but are considered as part of the submitted fee for the global surgical procedure. General anesthesia and intravenous sedation are paid as a separate benefit only when medically or dentally necessary, as determined by the Plan Administrator (or its delegate), and when administered in conjunction with complex oral surgical procedures which are covered under the Plan.

8.04 Major Treatment. Major Treatment is designed to correct dental disease, defect or injury. The Preventive Dental Option does not cover Major Treatment. Major Treatment includes:

(a) Crowns, including

(1) Porcelain fused to high noble metal

(2) Full cast, high noble metal

(3) Three-fourths cast, metallic

Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

(b) Removable appliances, including

(1) Complete (full) dentures, upper or lower

(2) Partial dentures

(3) Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)

(4) Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)

(c) Fixed appliances, including

(1) Bridge pontics - cast high noble metal

(2) Bridge pontics - porcelain fused to high noble metal

(3) Bridge pontics - resin with high noble metal

(4) Retainer crowns - resin with high noble metal

(5) Retainer crowns - porcelain fused to high noble metal

(6) Retainer crowns - full cast high noble metal

(d) Prosthetic device, supported by an implant or implant abutment. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is a Covered Expense only if the existing prosthesis is at least five calendar years old, is not serviceable and cannot be repaired.

(e) Implants, including the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is a Covered Expense only if the implant is not serviceable and cannot be repaired. Implant coverage is subject to a separate Plan Year maximum.

8.05 Orthodontia. The Preventive Dental and Dental Plan Options do not cover orthodontia. Orthodontia is covered under the Dental Plus Option, provided the Covered Person remains covered under such Coverage Option throughout the course of treatment. Orthodontia includes:

(a) Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances;

(b) Continued active treatment after the first month.

(c) Fixed or removable appliances, limited to one appliance per person for tooth guidance or to control harmful habits.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every three months. The first benefit payment is payable when the appliance is installed. Later payments are payable at the end of each three-month period. The first installment is the lesser of (x) the lifetime maximum for orthodontia services, or (y) the product of (i) 25% of the charge for the entire course of treatment, multiplied by (ii) the applicable Covered Percentage. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is covered under the Dental Plus Option. If coverage ends or treatment ceases, payment for the last three-month period will be prorated.

ARTICLE IX
GENERAL EXCLUSIONS

Notwithstanding any other Plan provision, the Plan shall not provide coverage for any of the following charges:

(a) Replacement of teeth that are missing when a person first becomes covered under the Plan;

(b) Services performed solely for cosmetic reasons;

(c) Replacement of a lost or stolen appliance;

(d) Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an Injury received while a Covered Person;

(e) Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;

(f) Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;

(g) Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;

(h) Bite registrations; precision or semiprecision attachments; or splinting;

(i) Instruction for plaque control, oral hygiene and diet;

(j) Dental services that do not meet common dental standards;

(k) Services that are deemed to be medical services;

(l) Services and supplies received from a hospital;

(m) Charges for expenses that are incurred:

(1) Before the effective date of coverage under the Plan;

(2) After the date on which the coverage under the Plan terminates; or

(3) For covered dental treatment that is completed after the date on which coverage under the Plan terminates;

(n) Charges not specified in this Plan as covered;

(o) Charges for services and supplies not prescribed or approved by a Dentist or Physician;

(p) Except as otherwise provided, expenses paid or payable under any other dental plan contributed to by an Employer;

(q) Charges for which claims are not filed on a timely basis in accordance with Plan provisions;

(r) Charges for legal expenses, whether or not incurred to obtain dental treatment;

(s) Services for which benefits are not payable according to the immediately following paragraph

In addition to the foregoing, no payment will be made for expenses incurred for a Participant or a Participant's Dependent:

(t) For or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;

(u) For or in connection with a Sickness which is covered under any workers' compensation or similar law;

(v) For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition;

(w) For charges for services provided by the Covered Person's parent, Spouse, brother, sister, son or daughter;

(x) For services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared;

(y) To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred;

(z) For charges which the Covered Person is not legally required to pay;

(aa) For charges which would not have been made if the Covered Person had no insurance;

(bb) To the extent that billed charges exceed the rate of reimbursement described in the Plan, including any charge in excess of the Maximum Reimbursable Charge;

(cc) For charges for care, treatment or surgery that is not Medically Necessary;

(dd) To the extent that the Participant or any Participant's Dependent is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

(ee) For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

ARTICLE X
SUBROGATION

10.01 Subrogation. If an Other Party is liable or legally responsible to pay expenses, compensation and/or damages in relation to a Sickness or an Injury incurred by any Covered Person, and benefits are payable under the Plan in relation to such Sickness or Injury, the Plan shall be subrogated to all rights of recovery of such Covered Person. The Covered Person or his or her legal representative shall transfer to the Plan any rights he or she may have to take legal action arising from the Sickness or Injury so that the Plan may recover any sums paid on behalf of the Covered Person. If the Covered Person fails to take legal action against an Other Party, and the Plan elects to take such legal action against such Other Party, in addition to the right to recover Plan benefits paid, the Plan shall be entitled to all expenses, including reasonable attorney's fees, incurred for such recovery. If the Plan recovers an amount greater than Plan benefits paid, the excess, reduced by the expenses of recovery, including reasonable attorney's fees, shall be paid to the Covered Person. The Plan shall have the right, with prior notice to, but without the consent of, the Covered Person, to compromise the amount of its claim if, in the opinion of the Plan Administrator, it is appropriate to do so.

10.02 Right of Recovery. The Plan may recover from a Covered Person or his or her legal representative the amount of any benefits paid under the Plan from any payment the Covered Person receives or is entitled to receive from an Other Party. The Plan shall not be responsible for any attorney's fees associated with any payment received by a Covered Person, unless the Plan expressly assumes such obligation prior to the Covered Person's recovery. Accordingly, unless the Plan expressly agrees otherwise, its recovery shall not be offset by any attorney's fees incurred by a Covered Person.

10.03 Application to Funds Recovered. For the avoidance of doubt, the Plan's right of subrogation described in Section 10.01 and its right of recovery described in Section 10.02 apply to any funds recovered from an Other Party by or on behalf an Employee, an Employee'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 the provisions of Sections 10.01 and 10.02, regardless of state law and whether the minor's representative has access to, or control of, any recovery funds.

10.04 Cooperation Required. The Covered Person or his or her legal representative shall cooperate fully with the Plan in asserting its subrogation and recovery rights. The Covered Person or his or her legal representative shall, upon request from the Plan, provide all information and sign and return all documents or agreements deemed by the Plan Administrator to be necessary for the Plan to exercise its rights under this Article. No Covered Person shall take any action to prejudice the Plan's subrogation rights. Each Covered Person shall provide notice to the Plan within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. As a condition of participating in the Plan, each Covered Person acknowledges that the Plan has a right to intervene in any lawsuit involving an Other Party, and such Covered Person consents to the unfettered exercise of that right. Failure or refusal to execute any of the

aforementioned documents or agreements or to furnish information, to comply with the obligations under such agreements or to cooperate fully with the Plan in asserting its subrogation and recovery rights does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement, and in such case, the Plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

10.05 First Lien Created. The Plan shall have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation, arbitration or any other means, that the Covered Person receives or is entitled to receive from any Other Party. 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 Plan. Such lien shall not exceed the lesser of:

(a) The amount of benefits paid by the Plan for the Sickness or Injury, plus the amount of all future benefits that may become payable under the Plan that result from the Sickness or Injury. The Plan shall have the right to offset or recover such future benefits from the amount received from the Other Party; or

(b) The amount recovered from the Other Party.

The Plan's first lien rights will not be reduced (1) due to the Covered Person's own negligence; (2) due to the Covered Person not being made whole; or (3) due to any attorney's fees and costs incurred by the Covered Person. Without limiting the generality of the foregoing, neither the "common fund" or "make whole" doctrines shall be applicable with regard to the Plan, and as a condition of participating in the Plan, each 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.

10.06 Constructive 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 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 Plan in accordance with this Article, and that such funds shall be held in a constructive trust until distributed in accordance with this Article.

10.07 Personal Liability Created. If a Covered Person or his or her legal representative makes any recovery from any Other Party and fails to reimburse the Plan for any benefits paid as a result of the Sickness or Injury, then (1) the Covered Person or his or her legal representative shall be personally liable to the Plan for the amount of the benefits paid under the Plan; and (2) the Plan may reduce future benefits payable by the amount of payment that the Covered Person or his or her legal representative has received from the Other Party. If the Plan institutes legal action against a Covered Person who fails to reimburse the Plan as required by this Section, in addition to liability to the Plan for the amount of benefits paid under the Plan, such Covered Person shall be liable to the Plan for the amount of the Plan's costs of collection, including reasonable attorney's fees.

ARTICLE XI
NONDUPLICATION OF BENEFITS

11.01 General. Nonduplication of Benefits rules set forth the order of payment of Covered Expenses when two or more plans, including Medicare, are liable for payment. This Article shall not apply to benefits obtained by a Covered Person from an individual dental insurance policy under which such Covered Person is entitled to benefits as a named person.

11.02 Definitions. For purposes of this Article, the following definitions shall apply:

(a) "Allowable Expense" shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made.

(b) "Plan" or "Benefit Plan" means this Plan or any one of the following plans:

(1) Group or blanket benefit plans, including health maintenance organizations;

(2) Blue Cross and Blue Shield group plans;

(3) Group practice and other group prepayment plans;

(4) Federal government plans or programs, including Medicare;

(5) Other plans required or provided by law; and

(6) "No fault vehicle insurance," by whatever name it is called, when inclusion is not prohibited by law.

"Plan" or "Benefit Plan" shall not encompass Medicaid or any other plan, program, policy or arrangement that, by its terms, does not allow coordination, integration or carve out of benefits.

(c) "Order of Benefits Determination" shall mean the method for ascertaining the order in which the Plan renders payment hereunder.

11.03 Application of the Rules. The Plan that is obligated to pay its benefits first shall be known as the "Primary" Plan. The Plan that, by its terms, is obligated to pay additional benefits for Allowable Expenses not paid by the Primary Plan is known as the "Secondary" Plan. Where another Plan contains a provision providing for coordination, integration or carve-out of benefits, the following Order of Benefits Determination shall establish the responsibility for payment hereunder:

(a) The Plan covering the patient as an Employee shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the patient as a dependent.

(b) The Plan covering the patient as a dependent of a person with a birthday earlier in the year shall be deemed to be the Primary Plan and is obligated to pay before the plan covering the patient as a dependent of a person with a birthday later in the year. In the event of divorce or legal separation, the following order shall establish responsibility for payment.

(1) If a court decree has determined financial responsibility for a child's dental care expenses, the Plan of the parent having that responsibility is Primary. If the parent with financial responsibility has no coverage for the child's dental care expenses, but that parent's Spouse does, such Spouse's Plan is Primary.

(2) The Plan of the parent with custody of the child pays before the Plan of the other parent or the Plan of any stepparent.

(3) The Plan of the stepparent married to the parent with custody of the child pays first.

(4) The Plan of the parent without custody of the child pays before the non custodial stepparent.

If this Order of Benefits Determination is not recognized by the other Plan, the order will be determined at the option of the Claims Administrator on a case by case basis.

(c) Where the order of payment cannot be determined in accordance with (a) and (b) above, the Primary Plan shall be deemed to be the Plan that has covered the patient for the longer period of time.

11.04 Plan as Primary Payor. If this Plan is Primary, it will provide payment in accordance with its terms.

11.05 Plan as Secondary Payor. If this Plan is Secondary, it will provide payment in accordance with its terms, considering as a Covered Expense the amount that would have been a Covered Expense in the absence of the Primary Plan, less the amount payable from the Primary Plan.

11.06 When Other Plan Has No Nonduplication of Benefits Rules. This Plan shall be considered to be Secondary when the other Plan does not contain a coordination, integration or carve out of benefits provision, or if the other Plan provides that it will be Secondary payor in all instances.

11.07 Vehicle Coverage Limitation. When dental benefits are available under vehicle insurance, this Plan shall always be considered as Secondary regardless of the individual's election under PIP (personal injury protection) coverage with the vehicle insurance carrier.

11.08 If Medicare Is Involved.

(a) General. Notwithstanding anything be in the Plan to the contrary, the provisions of this Section apply if Medicare is involved. Medicare shall be deemed to be "involved" if any Covered Person is eligible for benefits from Medicare, regardless of whether such Person has enrolled for coverage under Medicare. A Medicare-eligible Covered Person who fails to enroll for Medicare coverage shall be deemed to be enrolled under Medicare parts A and B.

(b) Definitions. The following terms have the meanings set forth herein for purposes of this Section:

(1) "Benefits" means any service or supply for which an Medicare Advantage Organization incurs a liability under an Medicare Advantage plan.

(2) "Current Employment Status" has the meaning given such term in 42 C.F.R. § 411.104, or in any successor regulation or provision implementing the Medicare Secondary Payer Rule, 42 U.S.C. § 1395y(b)(1).

(3) "Medicare Advantage Plan Enrollee" means an Medicare Advantage eligible individual who has enrolled in an Medicare Advantage Plan.

(4) "Medicare Advantage Organization" means a public or private entity organized and licensed by a State as a risk bearing entity (with the exception of provider sponsored organizations receiving waivers) that is certified by the Centers for Medicare and Medicaid Services ("CMS") as meeting the requirements for participation in the Medicare Advantage program.

(5) "Medicare Advantage Plan" means health benefits coverage offered under a policy or contract by an Medicare Advantage Organization.

(6) "Medicare Advantage Provider" means any provider authorized to provide medical services or supplies under the Medicare Advantage program.

(7) "Medicare Advantage Provider Network" means the Medicare Advantage Providers with which an Medicare Advantage Organization contracts or makes arrangements to furnish covered health care services to Medicare Advantage Plan Enrollees.

(8) "Medicare" means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as amended.

(9) "Order of Benefits Determination" means the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

(10) "Person" means a person who is eligible for benefits as a Covered Person under this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

(c) Order of Benefits Determination. When Medicare is involved, the order of Benefits Determination shall be as follows:

(1) For Employees who are Covered Persons with Current Employment Status, and for their Dependents who are Covered Persons, this Plan will be Primary payor and Medicare will be Secondary payor.

(2) For Covered Persons who are not in Current Employment Status and who are eligible for Medicare by reason of age alone, and for their Dependents who are Covered Persons and eligible for Medicare, this Plan will be Secondary payor and Medicare will be Primary payor.

(3) For Covered Persons eligible for Medicare, either entirely or in part, by reason other than age, the following provisions shall apply:

(A) For persons eligible for Medicare by reason of disability, the following provisions shall apply:

(i) For Employees who are not actively working and have received disability benefits from an Employer for more than six months, and for their Dependents, this Plan will be Secondary payor and Medicare will be Primary payor.

(ii) For Employees who are not actively working and have COBRA continuation coverage or who are otherwise not in Current Employment Status, and for their Dependents, this Plan will be Secondary payor and Medicare will be Primary payor.

(B) Subject to subparagraph (C) below, for a Covered Person eligible for Medicare by reason of end-stage renal disease, benefits of this Plan shall be Primary during the initial thirty-month period that begins on the date such Covered Person first becomes eligible for Medicare due to end-stage renal disease. Once the thirty-month period has expired, Medicare shall be Primary.

(C) For a Covered Person eligible for Medicare by reason of end-stage renal disease and for whom Medicare was already Primary at the time such Covered Person became eligible for Medicare due to end-stage renal disease, benefits of this Plan shall continue to be Secondary and Medicare shall be Primary. Provided, however, that Medicare must have been Primary at the time the Covered Person became eligible for Medicare due to end-stage renal disease because all of the following are true: (i) the Covered Person was already entitled to Medicare on the basis of age or disability; (ii) the Covered Person did not have coverage under the Plan by virtue of his or her own Current Employment Status or the Current Employment Status of another Covered Person; and (iii) the Plan was Secondary because it had justifiably taken into account the age-based or disability based Medicare entitlement of the Covered Person.

(4) For Covered Persons who are Medicare Advantage Plan Enrollees, this Plan shall be either a Primary or Secondary payor in accordance with subparagraphs (1), (2) or (3) above.

(d) Payment Provisions. If this Plan is Secondary to Medicare, this Plan will provide payment in accordance with its terms, considering as a Covered Expense the amount that would have been a Covered Expense in the absence of Medicare, less (1) the amount payable from Medicare; and (2) the amount denied by Medicare for which a Covered Person is not legally responsible. An amount shall be deemed "payable" from or "denied" by Medicare without regard for whether the person is enrolled under Medicare. If an Medicare Advantage Plan Enrollee who is a Covered Person receives services or supplies for which no Benefits are payable because such services or supplies are from a provider that is not an Medicare Advantage Provider, or are provided outside of an Medicare Advantage Provider Network, this Plan, if a Secondary payor, shall provide benefits in the same amount as if the Covered Person had received Benefits.

ARTICLE XII
ADMINISTRATION OF PLAN

12.01 Committee to Administer the Plan. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA.

12.02 The Committee. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

12.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Plan;

(h) To determine the status and rights of all Covered Persons;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Plan;

(k) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Plan;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

12.04 Interpretative Authority. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any

parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Summary Plan Description thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

12.05 Appointment of the Claims Administrator. The Plan Administrator shall appoint a Claims Administrator to provide administrative services to the Plan Administrator in connection with the operation of the Plan and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons or entity serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

ARTICLE XIII
CLAIMS FOR BENEFITS

13.01 Consideration of Initial Claim.

(a) Filing Initial Claim. The Claims Administrator shall process benefit claims pursuant to the procedures set forth below. Initial Claims shall be filed within eighteen months from the date a charge is incurred. The Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator may decide benefit claims requiring a determination of whether an individual meets the requirements for eligibility under the terms of the Plan, which determination may result in a denial, reduction, or termination of, or failure to provide payment for, a benefit. Solely with respect to claims involving a determination of an individual's eligibility under the Plan, the term "Claims Administrator" as used in this Article shall refer also to the Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator.

(b) Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to permit a determination whether, or to what extent, benefits are covered or payable under the Plan. If the claimant does not provide sufficient information for the Claims Administrator to make such determination, then within 24 hours after the Claims Administrator's receipt of the claim, the claimant shall be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Claims Administrator shall notify the claimant of its decision regarding the claim within 48 hours of the earlier of (i) the Claims Administrator's receipt of the specified information, or (ii) the end of the period afforded the claimant to provide the specified additional information.

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 the ability of the claimant to regain maximum function, or in the opinion of the patient's Physician, 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.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the initial 15-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, within five days after receipt of the claim he or she shall be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Pre-Service Claim" is any claim where the Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide notice of an adverse benefit determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Plan if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the claimant does not provide sufficient information for the Claims Administrator to make a determination, the claimant shall receive notice of the specific information necessary to complete the claim. Once the claimant is notified he or she shall have a reasonable amount of time, but not less than 45 days from receipt of the notice, to provide the missing information.

A "Post-Service Claim" is any claim that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

(e) Concurrent Care Claims. In the case of an ongoing course of treatment, the claimant shall receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Claims Administrator shall notify the claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. If the request to extend any ongoing course of treatment is not an Urgent Care Claim, the Claims Administrator will treat the claim as either a Pre-Service Claim or a Post-Service Claim (as applicable) and will consider the claim according to the timeframes applicable to Pre-Service Claims or Post-Service Claims,

whichever applies. The Claims Administrator shall be solely responsible for handling all Concurrent Care Claims.

A "Concurrent Care Claim" is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding a request by a claimant to extend a course of treatment beyond what has been approved.

13.02 **If the Claims Administrator Makes an Adverse Benefit Determination Regarding the Initial Claim** . If the Claims Administrator makes an adverse benefit determination, it shall provide notice of the adverse benefit determination that (1) explains the specific reason for the adverse benefit determination; (2) refers to the specific Plan provisions on which the adverse benefit determination is based; (3) describes any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) describes the Plan's review procedures (as set forth below) and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on all appeals. An "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 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.

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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Claims Administrator denies a claimant's Urgent Care Claim in whole or in part, the Claims Administrator shall provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Claims Administrator shall provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

13.03 **Mandatory First-Level Internal Appeal to the Claims Administrator.**

(a) General. If the Claims Administrator makes an adverse benefit determination, a claimant or his or her duly authorized representative may request a review of such adverse benefit determination by the Claims Administrator by sending a written request for review to the Claims Administrator within 180 days of receipt of the Claims Administrator's notice of adverse benefit determination.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of

charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied or the coverage should not have been rescinded. The claimant's request shall include any adverse benefit determination letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

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

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 consultant 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 the claimant the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Expedited Review for Urgent Care Claims. In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, the claimant or the claimant's authorized representative must contact the Claims Administrator and provide at least the following information: (1) the claimant's name; (2) the date(s) of the medical service; (3) the specific medical condition or symptom; (4) the provider's name; (5) the service or supply for which approval of benefits was sought; and (6) any reasons why the appeal should be processed on a more expedited basis. The Claims Administrator shall notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

13.04 If the Claims Administrator Makes an Adverse Benefit Determination on a Mandatory First-Level Internal Appeal If the Claims Administrator makes an adverse benefit determination on a mandatory first-level internal appeal, it shall provide notice, in a manner calculated to be understood by the claimant of the adverse benefit determination, which notice shall (1) explain the specific reason for the adverse benefit determination; (2) refer to the specific Plan provisions on which the adverse benefit determination is based; (3) state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) describe any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (5) indicate that a claimant has a 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

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

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

13.05 Mandatory Second-Level Internal Appeal to the Claims Administrator of Pre-and Post-Service Claim Denials.

(a) General. If the Claims Administrator makes an adverse benefit determination with respect to a Pre-Service Claim or a Post-Service Claim on a mandatory first-level internal appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Claims Administrator by sending a written request for review to the Claims Administrator within 60 days of receipt of the Claims Administrator's notice of denial of the mandatory first-level internal appeal.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include the name of the employer, any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

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

If the denial 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 consultant 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 the claimant upon request the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(b) Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator shall notify the claimant 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 a claimant's request for review.

(c) Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

13.06 **If the Claims Administrator Makes an Adverse Benefit Determination on a Mandatory Second-Level Internal Appeal.** If the Claims Administrator makes an adverse benefit determination on a mandatory second-level internal appeal, it shall provide notice, in a manner calculated to be understood by the claimant of the adverse benefit determination (such determination a "final adverse benefit determination"), which notice shall (1) explain the specific reason for the adverse benefit determination; (2) refer to the specific Plan provisions on which the adverse benefit determination is based; (3) state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) describe any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (5) indicate that a claimant has a 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant 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 the claimant's medical circumstances) shall be provided to the claimant free

of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

13.07 Limitations Upon Civil Actions. No civil action regarding a claim for benefits under the Plan may be commenced unless the claims procedure process for internal appeals described in this Article XIII has been exhausted. In addition, in no event may any civil 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.

13.08 Construction of Section. This Article shall be construed in a manner consistent with Department of Labor Regulations governing claims procedures applicable to group health plans.

ARTICLE XIV
TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE

14.01 Cessation of Participation. Except as otherwise provided in this Article:

(a) An Employee shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date that the Plan is amended to terminate coverage with respect to an Employee;

(3) The date of death of the Employee;

(4) The last day of the month in which an Employee is no longer eligible for coverage under Article III, including without limitation as a result of the Employee's employer no longer being a Related Employer;

(5) The last day of the month in which an Employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided in the NiSource Military Leave of Absence Policy;

(6) The last day of the last month for which any required Covered Person Contribution was made, in the case of cessation of required Covered Person contributions;

(7) The last day of the month in which a leave of absence begins, except to the extent continuation coverage is required under Section 14.02 (relating to coverage required by the FMLA); or

(8) The last day of the month in which an Employee terminates employment.

If, after the Employee ceases to be actively employed due to his or her purported disability or other approved leave status, an Employer under its personnel policies continues to treat an individual as an Employee generally eligible for health and welfare

benefits offered by the Employer, then the Employee will continue to be treated as an Employee eligible to participate in the Plan, subject to the terms and conditions of the Plan. Provided, however, that such participation shall cease upon the earliest of any event set forth in (1) through (6) and (8) above.

(b) A Dependent shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date the Employee's coverage ends;

(3) The last day of the last month for which any required Covered Person Contributions for Dependent coverage were made, in the case of cessation of required Covered Person Contributions; or

(4) The last day of the month in which a Dependent no longer qualifies as a Dependent.

14.02 Leave of Absence Under the FMLA. Eligibility for Plan coverage shall continue for an Employee who is granted a leave of absence under the FMLA at the same level of contribution and under the same conditions as if the Employee had continued in employment. However, to the extent permitted by the FMLA, the Company may recover from the Employee its cost of coverage and benefits provided hereunder if the Employee fails to return from leave for reasons other than the continuation or onset of a serious health condition (as defined in the FMLA), or other circumstances beyond the control of the Employee. The Company may require that a claim that an Employee is unable to return to work because of the continuation, recurrence, or onset of a serious health condition be supported by certification of a health care provider.

14.03 Military Leave Policy. Coverage for a Covered Person shall continue to the extent provided under the NiSource Military Leave of Absence Policy and as required by applicable state or federal law.

14.04 Severance. Eligibility for Plan coverage shall continue for an Employee to the extent provided under any severance arrangement between such Employee and the Company. The level of contribution and the conditions of such continuation coverage shall be determined by the terms of the applicable severance agreement. The Plan's COBRA continuation of coverage provisions will be available to the extent required by law. Unless a severance arrangement expressly provides to the contrary, continuation coverage pursuant to this Section shall be deemed to be "subsidized COBRA Continuation Coverage" and shall count towards the COBRA Continuation Coverage period.

14.05 COBRA. The Plan offers continuation of coverage to the extent required by COBRA.

(a) Continuation of Coverage. If Plan coverage ends because of a Qualifying Event, a Qualified Beneficiary may elect to continue the Coverage Option in force immediately prior to the Qualifying Event, subject to the provisions below.

(b) Election Period. A Qualified Beneficiary may elect COBRA Continuation Coverage only during the election period. The election period begins on the date of the Qualifying Event and ends on the later of (1) 60 days after the date coverage would have stopped due to the Qualifying Event; or (2) 60 days after the date the Qualified Beneficiary is sent notice of the right to continue coverage under COBRA.

A Covered Employee or Spouse's election of COBRA Continuation Coverage shall be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

If COBRA Continuation Coverage is elected within the election period, coverage shall be reinstated retroactively to the date of the Qualifying Event. If a Qualified Beneficiary waives COBRA Continuation Coverage during the election period, the Qualified Beneficiary may revoke that waiver at any time before the end of the election period and elect COBRA Continuation Coverage retroactive to the date of the Qualifying Event.

(c) Coverage Period. COBRA Continuation Coverage shall begin as of the date of the Qualifying Event and shall continue until the earliest of the following dates:

(1) The date the Qualified Beneficiary first becomes entitled to benefits under Medicare.

(2) 18 months from the date of a Qualifying Event set forth in subsection 2.54(a) or (b).

(3) If a Qualifying Event set forth in subsection 2.54(a) or (b) occurs less than 18 months after the date a Covered Employee becomes entitled to Medicare benefits, the period of coverage for each Qualified Beneficiary other than the Covered Employee shall not terminate before the close of the 36-month period beginning on the date the Covered Employee becomes entitled to Medicare.

(4) If any Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time before the 61st day of COBRA Continuation Coverage resulting from a Qualifying Event set forth in subsection 2.54(a) or (b), any Qualified Beneficiary may elect an additional 11 months of COBRA Continuation Coverage if:

(A) The disabled Qualified Beneficiary provides the Plan Administrator with the Social Security Administration's determination of disability (i) within 60 days of the later of date the determination is issued and the date the Qualified Beneficiary loses coverage under the Plan as a result of the Qualifying Event, and (ii) within the initial 18 month COBRA Continuation period; and

(B) The Qualified Beneficiary agrees to pay the increased Covered Person Contribution necessary to continue the coverage for the additional 11 months.

COBRA Continuation Coverage shall automatically end before the additional 11-month period ends on the first day of the month coincident with or next following 30 days from the date that the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

(5) 36 months from the date coverage would have ended due to a Qualifying Event other than that set forth in subsection 2.54(a) or (b).

(6) The date on which the Company ceases to provide any Group Health Plan to any Employee.

(7) If the Qualified Beneficiary fails to make a required Covered Person Contribution, the end of the period for which the last contribution was made.

(8) The date the 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, and such Pre-existing condition limitation is permissible pursuant to HIPAA.

(9) The Separation Date, in the case of a person (A) who (i) is a former employee of the Company or of a Related Employer, of a CPG Related Employer, or of a Columbia Divested Company, and whose last employment with any of such parties prior to termination of employment was with a CPG Related Employer or a Columbia Divested Company (a "CPG Participant"), or (ii) is or was a dependent of a CPG Participant or of an employee of CPG or of a CPG Related Employer; and (B) whose coverage under the Plan ended prior to the Separation Date because of a Qualifying Event.

(d) Multiple Qualifying Events. If after the first Qualifying Event another Qualifying Event occurs, coverage may be continued for an additional period, up to 36 months from the first Qualifying Event.

(e) Notification Requirements. A Qualified Beneficiary shall notify the Plan Administrator within 60 days of the Qualifying Events set forth in subsection 2.54(e) or (f) or of a second Qualifying Event described in subsection 14.05(d). If such notice is not given, the Qualified Beneficiary shall not be eligible for COBRA Continuation Coverage.

(f) Required Contributions. Except as provided in subsection 14.05(g), the Company will not make any contribution toward the cost of COBRA Continuation Coverage. A Qualified Beneficiary electing COBRA Continuation Coverage shall be responsible for a Covered Person Contribution in the amount of 102% of what is calculated to be the total cost of the Coverage Option being continued, or in the case of an individual who is entitled to extended COBRA Continuation Coverage beyond 18 months pursuant to subsection 14.05(c)(4), 150% of what is calculated to be the average cost of the Coverage Option being continued. Premiums for the period of COBRA Continuation Coverage prior to the date of the election will be due 45 days after the COBRA Continuation Coverage is elected. Thereafter, monthly premiums shall be due the first day of the calendar month. There shall be a grace period of 30 days for the payment of regularly scheduled monthly premiums.

(g) Subsidized COBRA. The Company may subsidize all or a portion of the cost of COBRA Continuation Coverage. If the Company so elects, the period of such subsidized coverage shall count towards the COBRA Continuation Coverage period required under this Section.

(h) COBRA-Like Continuation Coverage for Same-Sex Domestic Partners. The Plan will make COBRA-like continuation coverage available to a Same-Sex Domestic Partner who is a Covered Person (and to a Same-Sex Domestic Partner's Child who is a Covered Person) under circumstances, and subject to the same, terms, conditions and limitations, that would entitle the lawful Spouse or Child of a Participant to elect COBRA continuation coverage. A Same-Sex Domestic Partner and a Child of a Same-Sex Domestic Partner shall have the same notice and other obligations with respect to such continuation coverage as a lawful Spouse or Child of a Participant has with respect to

COBRA continuation coverage. For purposes of this COBRA-like continuation coverage, a termination of a same-sex domestic partner relationship will be treated as a divorce.

ARTICLE XV
PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION

15.01 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 Plan must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

15.02 Permitted Uses and Disclosure. The Plan may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plan 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 Plan or the Privacy Standards.

15.03 Disclosures to Company. The Plan 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 Plan 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.

The Company, in its capacity as sponsor of the Plan, agrees to:

(a) not use or further disclose Protected Health Information received from the Plan other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

(c) not use or disclose Protected Health Information received from the Plan for employment-related actions and decisions;

(d) not use or disclose Protected Health Information received from the Plan in connection with any other benefit or employee benefit plan of the Company (except to the extent that such other benefit, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan is a part);

(e) report to the Privacy Official, acting on behalf of the Plan, any use or disclosure of Protected Health Information received from the Plan that is inconsistent with the uses or disclosures authorized by this Section and of which the Company becomes aware;

(f) make available Protected Health Information in accordance with 45 C.F.R. § 164.524 (pertaining to an individual's access to his or her own Protected Health Information) and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(g) make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(i) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("HHS") or to any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with 45 C.F.R. Subchapter C, Subpart E; and

(j) if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The foregoing restrictions do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the Company or any other Employer, acting in their respective capacities as an employer.

15.04 Adequate Separation. There shall be adequate separation between the Plan and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the following employees, classes of employees or other persons under the control of the Company or its affiliates may have access to Protected Health Information created under the Plan:

Privacy Official
Security Official
Members of the Benefits Department
HRIS-Benefits Analyst
Members of the Legal Department
Members of the Internal Audit Department
Members of the Committee
Any other employee of the Company or its affiliates who performs plan administration functions for the Plan and who is designated in writing by the Privacy Official or a member of the Committee as being entitled to access to Protected Health Information.

Access to and use by such individuals shall be restricted to the plan administration functions that the Company and its affiliates perform for the Plan. The Plan or the Company (or an affiliate) has 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 Plan. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plan governing their obligations under the Privacy Standards.

15.05 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 Plan. The terms of the applicable Business Associate Agreement shall address non compliance with the Privacy Standards by a Business Associate.

15.06 **Special Amendatory Authority**. The Privacy Official appointed by the Plan Administrator pursuant to the Privacy Standards shall be authorized to make and execute any amendment to this Article that such Privacy Official deems necessary or appropriate.

ARTICLE XVI
PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

16.01 **General**. The Department of Health and Human Services has issued Regulations, effective April 20, 2005, that govern the manner in which a group health plan, such as the Plan, must handle Electronic Protected Health Information. "Electronic Protected Health Information" refers to Protected Health Information that is (i) maintained in Electronic Media (as defined in 45 C.F.R. Section 160.103), or (ii) transmitted by Electronic Media.

16.02 **Duty of the Plan Sponsor**. The Company shall reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted to or by the Company on behalf of the Plan. To this end, the Company shall: (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Company creates, receives, maintains or transmits on behalf of the Plan; (ii) ensure that the adequate separation required by Section 15.04 above is supported by reasonable and appropriate security measures; (iii) ensure that any agent, including a subcontractor, to whom or which the Company provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and (iv) report to the Plan any security incident involving Electronic Protected Health Information of which the Company becomes aware.

ARTICLE XVII
MISCELLANEOUS PROVISIONS

17.01 **Assignment of Benefits**. Except as required by applicable law, no right or interest of any Covered Person, and no benefit payable at any time, under the 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 the Plan be liable for, or subject to, any obligation or liability of any Covered Person. Without limiting the generality of the foregoing, except as required by applicable law, no Covered Person may 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 the 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 the Plan, and any such attempted assignment or transfer is void.

Nothing contained herein, nor any course of dealing, act or omission on the part of the Plan, the Plan Administrator or any Claims Administrator or other party, shall be construed to make the

Plan liable to any third party to whom a Covered Person may be liable for medical care, treatment, services or supplies. Although the Plan may, at the direction of a Covered Person or otherwise, make payments directly to persons or institutions providing Covered Services under the Plan, no such direction or payment shall be deemed to constitute an assignment, or an acknowledgment or acceptance of any purported assignment, of any benefits or other rights or interests under the Plan, including without limitation any legal or equitable right to institute any court proceeding. Any such payments by the Plan shall constitute a complete discharge of the obligation of the Plan to such Covered Person. Under no circumstances will any person or institution providing medical care, treatment, services or supplies to a Covered Person be deemed a participant or beneficiary under the Plan.

If any Covered Person entitled to a benefit under the Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part, or if by reason of his or her bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then upon becoming aware of any 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 his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her Dependents, in a manner the Plan Administrator may deem proper.

17.02 Information To Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

17.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

17.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

17.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

17.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

17.07 Misrepresentation. Any material misrepresentation on the part of any Covered Person in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void. Without limiting the generality of the foregoing, a Participant's enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under the Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including termination of employment.

17.08 Inadvertent Error. Inadvertent error by the Plan Administrator in the keeping of records or the transmission of any Enrollment Form shall not deprive any Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

17.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the rights of the Company or of any Employer to discipline or terminate an Employee.

17.10 No Liability for Acts of Any Provider. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan for the acts of any Hospital in which he or she receives care, or for the acts of any Physician from whom he or she receives service under this Plan.

17.11 Covered Person's Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect; (2) the Covered Person does not respond to the notice sent to the current address; (3) there are conflicting claims to such payment; or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest. Each Participant shall also notify the Plan in writing when any person is no longer eligible for coverage as his or her Dependent hereunder.

17.12 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to offset the overpaid amount against future benefits that are payable or to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization. Without limiting the generality of the foregoing, the Plan shall have the right to recover any amounts it pays in respect of a person who is not an eligible Participant or Dependent.

17.13 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 17.13 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions

contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

17.14 Severability. In the event any portion of this Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Plan, and the balance of the Plan shall remain in full force and effect.

17.15 Participant Litigation. In any action or proceeding involving the Plan, Covered Persons or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

17.16 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

17.17 Notice. Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Claims Administrator, when addressed to it at its home office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Claims Administrator.

17.18 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XVIII
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

18.01 Plan Self-Insured. The Plan is a self-insured plan. All contributions made to the Plan are used to pay claims and related expenses thereunder.

18.02 Participants' and Dependents' Rights Unsecured. The right of a Covered Person or any other person to receive a distribution hereunder, shall be an unsecured claim against the general assets of the Company and no Covered Person or any other person shall have any rights in any amount allocated for his or her benefit under the terms of the Plan, or any other specific assets of the Company. All amounts allocated pursuant to the terms of the Plan shall constitute general assets of the Company and may be disposed of by the Committee at such time and for such purpose as it may deem appropriate. Benefits payable pursuant to the terms of the Plan shall be paid solely as required out of the general assets of the Company or from any other funding vehicle as may be established by the Company.

18.03 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. No amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration. To the extent that any applicable collective bargaining agreement imposes a more restrictive requirement regarding Plan eligibility or benefits than is set forth herein, such requirement, as applied solely to those Employees subject to the collective bargaining agreement, is incorporated herein by this reference.

18.04 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

18.05 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 12th day of December, 2017, to be effective as of January 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

FIRST AMENDMENT TO THE NISOURCE DENTAL PLAN

(As Amended and Restated Effective January 1, 2016)

WHEREAS, NiSource Inc. (the "Company") maintains the NiSource Dental Plan, as amended and restated effective January 1, 2016 (the "Plan"); and

WHEREAS, pursuant to Section 18.03 of the Plan, and subject to Section 18.05 thereof, the NiSource Benefits Committee (the "Committee") has reserved the right to amend the Plan; and

WHEREAS, pursuant to resolutions adopted by the Committee, the Committee desires (i) to amend the Plan, effective as of June 1, 2016, (i) to define the term "NIPSCO Represented Employee" and to provide that such term does not include, for the period from June 1, 2016 to April 30, 2019, specified participants in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and the Northern Indiana Public Service Company with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019, and (ii) to make other conforming changes to the Plan.

NOW, THEREFORE, the Plan is hereby amended, effective as June 1, 2016, as follows:

1. A new Section 2.66, "**NIPSCO Represented Employee**," is hereby added to the Plan and shall recite in its entirety as follows:

> **2.66 "NIPSCO Represented Employee"** means a Represented Employee who is employed by NIPSCO. For purposes of the Plan, notwithstanding any other provision herein, the terms "NIPSCO Represented Employee," "Represented" and "Represented Employee" shall not include any Employee employed by NIPSCO in the role of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) (hereinafter, "Damage Prevention Coordinator") during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and NIPSCO with respect to such position for the period (the "Specified Period") specified in the MOU from June 1, 2016 to April 30, 2019, unless such Employee was considered a NIPSCO Represented Employee immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator. Effective as of May 1, 2019, Employees employed by NIPSCO in the position of Damage Prevention Coordinator shall be considered NIPSCO Represented Employees and Represented Employees for purposes of the Plan, unless otherwise negotiated in an agreement between the bargaining unit and NIPSCO.

2. Section 4.01, "**Eligibility,**" of Article IV, "**Preventive Dental Option,**" of the Plan is hereby amended to recite in its entirety as follows:

4.01 **Eligibility**. The Preventive Dental Option shall be available to all eligible Employees and Dependents as described in Article III, except NIPSCO Represented Employees.

3. All other provisions of the Plan shall remain unchanged.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this First Amendment to the NiSource Dental Plan to be executed on its behalf by one of its members duly authorized, effective as of June 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

NISOURCE VISION PLAN

As Amended and Restated
Effective as of January 1, 2016

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1

ARTICLE II DEFINITIONS 1
2.01 "Adopted Child" 1
2.02 "Annual Enrollment Period" 1
2.03 "Applicable SPD" 1
2.04 "Basic Vision Option" 1
2.05 "Category of Coverage" 1
2.06 "Child" 1
2.07 "COBRA" 1
2.08 "COBRA Continuation Coverage" 1
2.09 "Code" 2
2.10 "Columbia Divested Company" 2
2.11 "Committee" 2
2.12 "Company" 2
2.13 "Coverage Option" 2
2.14 "Covered Employee" 2
2.15 "Covered Person" 2
2.16 "Covered Person Contribution" 2
2.17 "Covered Same-Sex Domestic Partner" 2
2.18 "CPG" 2
2.19 "CPG Related Employer" 2
2.20 "CPG Spin-Off" 2
2.21 "Dependent" 2
2.22 "Employee" 3
2.23 "Employer" 3
2.24 "ERISA" 4
2.25 "Financially Interdependent" 4
2.26 "Flexible Benefits Plan" 4
2.27 "FMLA" 4
2.28 "Foster Child" 4
2.29 "Group Health Plan" 4
2.30 "Insurer" 4
2.31 "Legal Ward" 4
2.32 "Medicare" 5
2.33 "No Coverage Option" 5
2.34 "Participant" 5
2.35 "Plan" 5
2.36 "Plan Administrator" 5
2.37 "Plan Year" 5
2.38 "Qualified Beneficiary" 5
2.39 "Qualifying Event" 5
2.40 "Related Employer" 5
2.41 "Represented" 6
2.42 "Same-Sex Domestic Partner" 6
2.43 "Separation Date" 6
2.44 "Spouse" 6

2.45 "Status Change" 6
2.46 "Stepchild" 7

ARTICLE III PARTICIPATION 8
3.01 Eligibility 8
3.02 Enrollment 8
3.03 Categories of Coverage 10
3.04 Election of a Category of Coverage 10
3.05 Election of a Coverage Option 10

ARTICLE IV CONTRIBUTIONS TO THE PLAN 11
4.01 Covered Person Contributions 11
4.02 Employer Contributions 11

ARTICLE V BENEFITS 11
5.01 General 11
5.02 Payment of Benefits 11
5.03 Designation of Beneficiaries 11

ARTICLE VI GENERAL EXCLUSIONS 11

ARTICLE VII SUBROGATION 11

ARTICLE VIII COORDINATION OF BENEFITS 11

ARTICLE IX ADMINISTRATION OF PLAN 12
9.01 Committee to Administer the Plan 12
9.02 The Committee 12
9.03 Powers of the Plan Administrator 12
9.04 Interpretative Authority 12

ARTICLE X CLAIMS FOR BENEFITS 13

ARTICLE XI TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE 13
11.01 Cessation of Participation 13
11.02 Leave of Absence Under the FMLA 14
11.03 Military Leave Policy 14
11.04 Severance 14
11.05 COBRA 14

ARTICLE XII PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION 17
12.01 General 17
12.02 Permitted Uses and Disclosure 17
12.03 Disclosures to Company 17
12.04 Adequate Separation 18
12.05 Unauthorized Use or Disclosure 19
12.06 Special Amendatory Authority 19

ARTICLE XIII PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION 19
13.01 General 19
13.02 Duty of the Plan Sponsor 19

ARTICLE XIV MISCELLANEOUS PROVISIONS 19
14.01 Assignment of Benefits 19
14.02 Information To Be Furnished 19
14.03 Limitation of Rights 20
14.04 Plan Not Contract 20
14.05 Fiduciary Operation 20
14.06 No Guaranty 20
14.07 Misrepresentation 20
14.08 Inadvertent Error 20
14.09 No Limitation of Management Rights 20
14.10 Covered Person's Responsibilities 20
14.11 Right of Recovery 21
14.12 Governing Law and Venue 21
14.13 Severability 21
14.14 Participant Litigation 21
14.15 Counterparts 21
14.16 Notice 21
14.17 Extension of Plan to Related Employers 22

ARTICLE XV FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 22
15.01 Plan Fully-Insured 22
15.02 Amendment 22
15.03 Termination 22
15.04 Collective Bargaining Agreement 22

ARTICLE I
INTRODUCTION

NiSource Inc. established the Plan in 2004 to provide vision benefits for the participants and beneficiaries hereunder. The Plan was subsequently amended and restated effective as of January 1, 2006, as of January 1, 2008, as of January 1, 2011, as of January 1, 2013, as of January 1, 2014, January 1, 2015, and July 1, 2015, to reflect various plan design changes and certain statutory and regulatory changes. This is an amended and restated version of the Plan, effective as of January 1, 2016, that reflects certain plan design changes.

ARTICLE II
DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

2.01 **"Adopted Child"** means any child legally adopted by, or placed for adoption with, a Participant or Covered Same-Sex Domestic Partner.

2.02 **"Annual Enrollment Period"** means the period selected by the Company each year during which time an Employee may select coverage to be effective for the following Plan Year.

2.03 **"Applicable SPD"** means the summary plan description applicable to the group of Employees or Dependents to which a Covered Person belongs. Each Applicable SPD shall be considered a part of the Plan and shall be consistent with the group policy that funds Plan benefits. To the extent an Applicable SPD is inconsistent with any such group policy, the terms of the group policy shall control.

2.04 **"Basic Vision Option"** means the Basic Vision Option described in the Applicable SPD.

2.05 **"Category of Coverage"** means a coverage choice (e.g., Employee only, Employee + Family, no coverage), if any, offered within each Coverage Option, as described in the Applicable SPD or as permitted by the group policy that funds Plan benefits.

2.06 **"Child"** means a person who is either (1) a naturally born child of a Participant; (2) an Adopted Child; (3) a Stepchild; (4) a Foster Child; (5) a Legal Ward who is dependent upon a Participant or Covered Same-Sex Domestic Partner for at least 50% of his or her financial support and who may be claimed the income tax return of the Participant or Covered Same-Sex Domestic Partner as a dependent (without giving effect to the Legal Ward's gross income); or (6) any person deemed by court order to be a Child for purposes of the Plan.

2.07 **"COBRA"** means Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.08 **"COBRA Continuation Coverage"** means continuation coverage to the extent required by COBRA.

2.09 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.10 **"Columbia Divested Company"** means any one of the following companies that previously was affiliated with a Related Employer: Columbia Energy Services Corp., Columbia Propane Corporation, Columbia Electric Corporation, Columbia LNG Corporation, Energy.com Corporation, Columbia Trans Communications, Commonwealth Propane, Columbia Propane LP, Columbia Petroleum Corporation, Columbia Natural Resources Inc., Hawg Hauling & Disposal Inc., Coal Gas, CS-42, Gas Development, New York Gas & Elec, Pittsburgh Market Division and Columbia Gas of West Virginia.

2.11 **"Committee"** means the NiSource Benefits Committee or its predecessor , the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

2.12 **"Company"** means NiSource Inc., a Delaware corporation.

2.13 **"Coverage Option"** means any coverage option described in the Applicable SPD.

2.14 **"Covered Employee"** means an individual who is (or was) provided coverage under the Plan by virtue of the performance of services by the individual for an Employer.

2.15 **"Covered Person"** means an Employee or Dependent covered under the Plan.

2.16 **"Covered Person Contribution"** means the contribution required under Section 4.01.

2.17 **"Covered Same-Sex Domestic Partner"** means a Same-Sex Domestic Partner covered under the Plan.

2.18 **"CPG"** means Columbia Pipeline Group, Inc., a Delaware corporation.

2.19 **"CPG Related Employer"** means, on and after the Separation Date, (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes CPG; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with CPG; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes CPG.

2.20 **"CPG Spin-Off"** means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG

2.21 **"Dependent"** means, subject to any additional limitations set forth in the Applicable SPD or in the group policy that funds Plan benefits:

(a) The Spouse of a Participant, if not legally separated;

(b) The Same-Sex Domestic Partner of a Participant;

(c) A Child who has not attained 26 years of age;

(d) An unmarried Child who satisfies the "dependency test" described in this Section 2.21 and who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the Child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date Dependent status would otherwise terminate and is provided to the Claims Administrator every three years

thereafter, or more frequently if requested by the Claims Administrator; (2) the Child is dependent upon the Participant (or Covered Same-Sex Domestic Partner of the Participant, as the case may be) for financial support and maintenance; (3) the Employee continues to be covered by the Plan; and (4) the Child's disability continues; or

(e) A Child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient under ERISA, as having a right to participate in the Plan as a Dependent.

For purposes of this Section 2.17, a Child of a Participant or of a Covered Same-Sex Domestic Partner satisfies the "dependency test" for a particular Plan Year if

(x) the Participant or the Covered Same-Sex Domestic Partner would be allowed a dependent exemption for such Child in computing his or her federal taxable income for such Plan Year, or

(y) each of the following conditions is satisfied: (1) such Child receives over half of his or her support during the Plan Year from his or her parents and is in the custody of one or both parents for more than half of the Plan 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 Plan 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 month of the Plan Year.

For purposes of the "dependency test" in clause (x) above, the Child's gross income for such Plan Year may be ignored in determining whether the Participant or Covered Same-Sex Domestic Partner would be entitled to a dependent exemption for such Child for such Plan Year.

Notwithstanding any other provision of the Plan, but subject to the provisions of Section 11.05(h), regarding COBRA-like continuation coverage for a Covered Person under the circumstances described therein, provided the Covered Person was entitled to such coverage immediately prior to January 1, 2017, effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child shall be a Dependent eligible for coverage, or entitled to any benefits, under the Plan.

2.22 **"Employee"** means an employee eligible for coverage under an Applicable SPD. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.23 **"Employer"** means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that a group health plan providing vision benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall

automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.23, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

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

2.25 **"Financially Interdependent"** means that a Participant and another person satisfy any two of the following conditions:

(a) the Participant designates such other person as the Participant's beneficiary for employer-sponsored retirement or life insurance benefits;

(b) the Participant designates such other person as the primary beneficiary under the Participant's will;

(c) the Participant designates such other person as the Participant's attorney-in-fact under a durable power of attorney for health care;

(d) the Participant and such other person have a common ownership or leasehold interest in real property;

(e) the Participant and such other person have joint bank or credit accounts or joint investments; or

(f) the Participant and such other person have joint liability for a mortgage, lease or loan.

2.26 **"Flexible Benefits Plan"** means the NiSource Flexible Benefits Plan, as amended or restated from time to time.

2.27 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

2.28 **"Foster Child"** means a child legally placed in the custody of a Participant or Covered Same-Sex Domestic Partner by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, who is receiving parental care from such Participant Covered Same-Sex Domestic Partner, and for whom such Participant or Covered Same-Sex Domestic Partner is legally responsible to provide medical care.

2.29 **"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

2.30 **"Insurer"** means the insurance carrier selected by the Plan Administrator or the Plan to issue the group policy that insures plan benefits.

2.31 **"Legal Ward"** means any Child for whom a Participant or Covered Same-Sex Domestic Partner is legal guardian, provided that such Child is dependent on such Participant or Covered Same-Sex Domestic Partner for principal support and maintenance.

2.32 **"Medicare"** means the program of medical care benefits provided for aged and disabled persons under the Social Security Act of 1965, as amended.

2.33 **"No Coverage Option"** means an Employee's election not to become covered under a Coverage Option.

2.34 **"Participant"** means each Employee who is a Covered Person.

2.35 **"Plan"** means the NiSource Vision Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.37 **"Plan Year"** means the calendar year.

2.38 **"Qualified Beneficiary"** means:

(a) Any persons who were Covered Persons on the date immediately preceding a Qualifying Event as:

(1) An Employee;

(2) An Employee's Spouse; or

(3) A Dependent Child.

(b) A Child who is born to or placed for adoption with a Covered Employee who is a Qualified Beneficiary during a period of COBRA Continuation Coverage. The COBRA Continuation Coverage period for such a Qualified Beneficiary shall run from his or her birth or adoption to the end of the COBRA Coverage period for all Qualified Beneficiaries entitled to COBRA coverage as a result of the same Qualifying Event.

2.39 **"Qualifying Event"** means any of the following that results in loss of coverage for a Qualified Beneficiary:

(a) The Covered Employee's employment ends (except in the case of gross misconduct);

(b) The Covered Employee's work hours are reduced;

(c) The Covered Employee becomes entitled to benefits under Medicare;

(d) The Covered Employee's death;

(e) The divorce or legal separation of the Covered Employee from the Covered Employee's Spouse; or

(f) A Dependent Child is no longer an eligible Dependent.

2.40 **"Related Employer"** means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section

414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.41 **"Represented"** means an Employee who is covered by a collective bargaining agreement between an Employer and a union.

2.42 **"Same-Sex Domestic Partner"** means, with respect to a Participant, a person of the same sex as the Participant, if the Participant and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is the Participant's registered domestic partner, or is a party to a civil union with the Participant, under the laws of the Participant's state of residence; or

(b) The Participant and such person

(1) are both age 18 or older and competent to enter into a legal contract;

(2) have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are Financially Interdependent;

(3) share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in the Participant's state of residence;

(4) reside in a state that, prior to June 26, 2015, did not recognize or permit same-sex marriage, domestic partner registration or civil union;

(5) are not currently married to, a party to a civil union with, or the domestic partner, of any other person;

(6) intend that their same-sex domestic partnership be of unlimited duration; and

(7) do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

Notwithstanding the foregoing, a person shall not be a Same-Sex Domestic Partner if he is otherwise ineligible for coverage under the terms of the certificate of coverage, group insurance policy or other governing document issued by the Insurer.

From time to time, a Participant may be required to confirm orally, electronically or in writing, in a manner prescribed by the Plan Administrator, that the Participant and his or her Same-Sex Domestic Partner satisfy the foregoing eligibility requirements.

2.43 **"Separation Date"** means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

2.44 **"Spouse"** means a person who is treated as a spouse under the Code.

2.45 **"Status Change"** means any of the following:

(a) Legal Marital Status. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(b) Number of Dependents. Events that change an Employee's number of Dependents, including birth, adoption, placement for adoption (as defined in Treasury Regulations under Code Section 9801), or death of a Dependent.

(c) Employment Status. A termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite that changes the employment status of an Employee, a Spouse or other Dependent, or any other change in the employment status of an Employee, a Spouse or other Dependent that makes such individual eligible or ineligible for coverage under the Plan (such as switching from full-time to part-time status or from salaried to hourly-paid).

(d) Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the Plan.

(e) Residence. A change in the place of residence of an Employee, a Spouse or other Dependent.

(f) Other Permissible Events. Any other event that the Plan Administrator or a member of the Committee determines to be a permissible Status Change under the Code or any regulation, ruling or release issued thereunder. Such determination shall be (1) consistent with the terms of the Plan; and (2) made in a uniform and non-discriminatory manner.

As used in this Section 2.45, and subject to the immediately following paragraph, the term "Dependent" shall include only those Dependents described in Section 2.21 above who would be considered a "dependent" for purposes of Code Section 125, the regulations thereunder, and Internal Revenue Service Notice 2010-38, as such statutory provision, regulations or guidance may be amended or modified from time to time.

Solely for purposes of this Section 2.45 and Section 3.02(c), and only for the period beginning January 1, 2013, and ending on December 31, 2016, a "Spouse" will be deemed to include a Participant's Same-Sex Domestic Partner, "marriage" will be deemed to include the establishment of a Same-Sex Domestic Partner relationship, "divorce" will be deemed to include the termination of a Same-Sex Domestic Partner relationship, and the term "Dependent" will be deemed to include a Same-Sex Domestic Partner and a Same-Sex Domestic Partner's Child; provided, however, that notwithstanding any other provision of the Plan, no Category of Coverage change under Section 3.02(c) involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee, in their sole discretion.

2.46 **"Stepchild"** means any natural or adopted child of a Participant's current Spouse or Same-Sex Domestic Partner, and any natural or adopted child of a former Spouse or Same-Sex Domestic Partner of a Participant living in the Participant's home in a familial relationship if the natural parents of such child are both deceased.

ARTICLE III
PARTICIPATION

3.01 Eligibility.

(a) Employees. Each Employee of an Employer may be covered under the Plan solely in accordance with the terms of the Applicable SPD.

(b) Dependents. A Dependent of a Participant may be covered by the Plan solely in accordance with the terms of the Applicable SPD.

3.02 Enrollment. Subject to the specific eligibility restrictions provided in the Applicable SPD, Employees shall be eligible to enroll in the Plan as follows:

(a) New Hires. As a condition of participation in the Plan, each Employee who becomes eligible to become covered under the Plan pursuant to Section 3.01 shall properly enroll such Employee and any Dependents such Employee desires to cover on or before the day the Employee first becomes eligible for coverage. Such enrollment shall be effective for the period beginning on the first day of eligibility and ending on the last day of the Plan Year in which such participation begins. An Employee who became eligible for coverage but fails to properly enroll shall be covered pursuant to Sections 3.04 and 3.05.

(b) Annual Enrollment Period. An Employee eligible for coverage may elect or change any coverage option by properly enrolling during the Annual Enrollment Period. Such election shall be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year; provided, however, if such Employee makes no election or change during the Annual Enrollment Period, such Employee shall be deemed to have elected to continue his or existing coverage option for the following Plan Year.

(c) Status Change Enrollment. If a Status Change occurs, an Employee may make a Category of Coverage change during the Status Change Enrollment Period provided under this subsection; provided, however, if required by Section 125 of the Code and the Regulations, rulings and releases issued thereunder, such change in coverage shall be consistent with the Status Change event. A change in coverage is consistent with a Status Change event only if (1) the Status Change results in an Employee or Dependent gaining or losing eligibility for coverage under either the Plan or a vision plan of the Dependent's employer; and (2) the change in coverage corresponds with such gain or loss of coverage. Such Status Change Enrollment Period shall begin on the date of the Status Change event, and shall expire 31 days thereafter. Accordingly, to obtain or modify coverage under this subsection, the Employee shall properly modify his or her enrollment during such Status Change Enrollment Period. Coverage under this subsection shall be effective as of the date it is approved by the Plan.

(d) Judgment, Decree or Order. An Employee may make a Category of Coverage change upon entry of a court judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in Section 609 of ERISA) that requires Plan coverage for a Child.

(e) Entitlement to Medicare or Medicaid. An Employee may make a Category of Coverage change if a Covered Person becomes enrolled under Medicare Parts A, B or C, or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the

Social Security Act (the program for distribution of pediatric vaccines). Any such Category of Coverage change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan.

(f) Automatic Cost Change. If the cost of the Plan increases or decreases during a Plan Year, a Participant is required to make a corresponding change in his or her payments under the Plan. In such event, on a prospective basis, the Plan Administrator shall automatically effectuate the increase or decrease in the Participant's elective Covered Person Contributions. In addition, the Plan Administrator may automatically make a prospective decrease in a Participant's elective Covered Person Contributions as a result of any event that causes the Participant to lose eligibility for coverage.

(g) Significant Cost Change. An Employee may make a Coverage Option change if the cost of a Coverage Option under the Plan significantly increases or decreases during a Plan Year. Any Coverage Option change must correspond with such increase or decrease in cost. Changes that are permitted include commencing participation in a Coverage Option that significantly decreases in cost, or, in the case of an Coverage Option that significantly increases in cost, revoking an election for that Coverage Option and, in lieu thereof, either receiving on a prospective basis coverage under another Coverage Option providing similar coverage or dropping the Coverage Option if no other Coverage Option providing similar coverage is available. Any such Coverage Option change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan.

(h) Significant Coverage Change. An Employee may make a Coverage Option change:

(1) If the coverage under a Coverage Option is significantly curtailed during a period of coverage, in which case the Participant may revoke his or her election for coverage under such Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Coverage Option providing similar coverage;

(2) If the coverage under a Coverage Option ceases during a period of coverage, in which case the Participant may revoke his or her election for coverage under such Coverage Option and, in lieu thereof, elect to receive on a prospective basis coverage under another Coverage Option providing similar coverage, or elect the No Coverage Option if no Coverage Option providing similar coverage is available;

(3) If the Plan adds a new benefit or other coverage option or the terms of a benefit offered under the Plan are significantly improved during a period of coverage; or

(4) On account of and corresponding with a change made under another employer's plan if (i) the other cafeteria plan or qualified benefits plan permits participants to make an election that is consistent with the permitted election change rules under Section 125 of the Code and the regulations issued thereunder, or (ii) the Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the other employer's cafeteria plan or qualified benefits plan.

Any such Coverage Option change shall be requested within the time period and in the manner specified in the Flexible Benefits Plan.

(i) Terms and Conditions Imposed by Insurer. Notwithstanding any other provision of the Plan, enrollment or a change in enrollment in the Plan shall be subject to any additional terms or conditions imposed by the Insurer.

(j) Changes Involving Same-Sex Domestic Partners. Notwithstanding any provision of this Section 3.02, no Category of Coverage change, Coverage Option change, or change in Covered Person Contributions in respect of an event involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's Child shall be made if such change would violate requirements of the Code or of any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee in their sole discretion, or would violate the requirements of the Insurer.

(k) Enrollment of Same-Sex Domestic Partners and Their Children. Effective January 1, 2017, no Employee may enroll a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's child for coverage under the Plan.

3.03 Categories of Coverage. The Plan offers the following Categories of Coverage:

(a) Employee-Only;

(b) Employee + Spouse;

(c) Employee + Child;

(d) Employee + Family; and

(e) No Coverage.

Where applicable, Categories of Coverage include an eligible Same-Sex Domestic Partner and an eligible Child of a Same-Sex Domestic Partner.

3.04 Election of a Category of Coverage. An Employee or Qualified Beneficiary may select or change a Category of Coverage during the enrollment periods set forth in Section 3.02 and subject to any requirements or limitations under the Flexible Benefits Plan. A Category of Coverage selection shall remain effective until properly changed during an Annual Enrollment Period or by reason of an event described in subsections 3.02(c)-(e). If a new hire fails to properly enroll, such new hire shall be deemed to have selected Employee-Only coverage.

3.05 Election of a Coverage Option. An Employee may select a Coverage Option as a new hire or during the Annual Enrollment Period. Such an Option selection shall remain effective until properly changed during an Annual Enrollment Period.

(a) If a newly hired Employee fails to properly enroll for coverage, such Employee shall be deemed to have selected the following Coverage Options:

(1) Employees of Bay State Gas Company represented by the United Steel Workers Local Union No. 12026 (Springfield Operating) shall have been deemed to have selected the No Coverage Option.

(2) All other Employees shall be deemed to have selected the Basic Vision Option.

(b) If an Employee fails to properly enroll for coverage during the Annual Enrollment Period, such Employee shall be deemed to have selected the same Coverage Option in place at the beginning of the Annual Enrollment Period:

ARTICLE IV
CONTRIBUTIONS TO THE PLAN

4.01 **Covered Person Contributions.** As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company or Plan Administrator.

4.02 **Employer Contributions.** The Employer will contribute to the cost of the Plan to the extent such cost exceeds the amount contributed by the Covered Person.

ARTICLE V
BENEFITS

5.01 **General.** Benefits under the Plan shall be determined and paid pursuant to the Applicable SPD.

5.02 **Payment of Benefits.** All benefits shall be paid to the Covered Person as determined by the Applicable SPD. Benefits shall be paid by the Insurer.

5.03 **Designation of Beneficiaries.** Each Covered Person from time to time may name any person or entity who shall be the Covered Person's beneficiary under the Plan. Each such beneficiary designation shall be made in accordance with procedures established by the Insurer. All determinations of the identity of any beneficiary shall be made by the Insurer. If a Covered Person fails to designate a beneficiary before his or her death, as provided above, or if the designated beneficiary dies before the date of the Covered Person's death or before complete payment of the Covered Person's benefits, Plan benefits shall be payable in accordance with procedures established by the Insurer.

ARTICLE VI
GENERAL EXCLUSIONS

The Plan shall not provide coverage for any exclusion set forth in the Applicable SPD.

ARTICLE VII
SUBROGATION

All Covered Persons shall be subject to any subrogation and any third-party recovery provisions as may be established by the Insurer.

ARTICLE VIII
COORDINATION OF BENEFITS

The Plan shall provide for the coordination of benefits as set forth in the Applicable SPD.

ARTICLE IX
ADMINISTRATION OF PLAN

9.01 Committee to Administer the Plan. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA. The Insurer shall be the Plan fiduciary responsible for all claims decisions, including appeals of denied claims.

9.02 The Committee. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

9.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Insurer to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine the status and rights of all Covered Persons;

(h) To make regulations and prescribe procedures;

(i) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Plan;

(j) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(k) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(l) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

9.04 Interpretative Authority. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Applicable SPD thereunder. Any writing, decision, determination of eligibility for coverage or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be

binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Insurer decides in its discretion that the applicant is entitled to them, in accordance with the provisions of the Plan.

ARTICLE X
CLAIMS FOR BENEFITS

All claims for benefits and appeals of denied claims shall be decided by the Insurer in accordance with the procedures contained in the Applicable SPD.

ARTICLE XI
TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE

11.01 Cessation of Participation. Except as otherwise provided in this Article:

(a) An Employee shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date that the Plan is amended to terminate coverage with respect to an Employee;

(3) The date of death of the Employee;

(4) The last day of the month in which an Employee is no longer eligible for coverage under Article III, including without limitation as a result of the Employee's employer no longer being a Related Employer;

(5) The last day of the month in which an Employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided under the NiSource Military Leave of Absence Policy;

(6) The last day of the last month for which any required Covered Person Contribution was made, in the case of cessation of required Covered Person Contributions;

(7) The last day of the month in which a leave of absence begins, except to the extent continuation coverage is required under Section 11.02 (relating to coverage required by the FMLA);

(8) The last day of the month in which an Employee terminates employment; or

(9) The date provided for coverage termination in the Applicable SPD.

If, after the Employee ceases to be actively employed due to his or her purported disability or other approved leave status, an Employer under its personnel policies continues to treat an individual as an Employee generally eligible for health and welfare

benefits offered by the Employer, then the Employee will continue to be treated as an Employee eligible to participate in the Plan, subject to the terms and conditions of the Plan. Provided, however, that such participation shall cease upon the earliest of any event set forth in (1) through (6) and (8) through (9) above.

(b) A Dependent shall cease to participate in the Plan on the earliest of the following dates:

(1) The date as of which the Plan is terminated;

(2) The date the Employee's coverage ends;

(3) The last day of the last month for which any required Covered Person Contributions for Dependent coverage were made, in the case of cessation of required Covered Person Contributions;

(4) The last day of the month in which a Dependent no longer qualifies as a Dependent; or

(5) The date provided for coverage termination in the Applicable SPD.

11.02 Leave of Absence Under the FMLA. Eligibility for Plan coverage shall continue for an Employee who is granted a leave of absence under the FMLA at the same level of contribution and under the same conditions as if the Employee had continued in employment. However, to the extent permitted by the FMLA, the Company may recover from the Employee its cost of coverage and benefits provided hereunder if the Employee fails to return from leave for reasons other than the continuation or onset of a serious health condition (as defined in the FMLA), or other circumstances beyond the control of the Employee. The Company may require that a claim that an Employee is unable to return to work because of the continuation, recurrence, or onset of a serious health condition be supported by certification of a health care provider.

11.03 Military Leave Policy. Coverage for a Covered Person shall continue to the extent provided under the NiSource Military Leave of Absence Policy and as required by applicable state or federal law.

11.04 Severance. Eligibility for Plan coverage shall continue for an Employee to the extent provided under any severance arrangement between such Employee and the Company. The level of contribution and the conditions of such continuation coverage shall be determined by the terms of the applicable severance agreement and are subject to approval for continuation coverage by the Insurer. The Plan's COBRA continuation of coverage provisions will be available to the extent required by law. Unless a severance arrangement expressly provides to the contrary, continuation coverage pursuant to this Section shall be deemed to be "subsidized COBRA Continuation Coverage" and shall count towards the maximum COBRA Continuation Coverage period.

11.05 COBRA. The Plan offers continuation of coverage to the extent required by COBRA and subject to any further limitations in the Applicable SPD or group policy funding Plan benefits.

(a) Continuation of Coverage. If Plan coverage ends because of a Qualifying Event, a Qualified Beneficiary may elect to continue the Coverage Option in force immediately prior to the Qualifying Event, subject to the provisions below.

(b) Election Period. A Qualified Beneficiary may elect COBRA Continuation Coverage only during the election period. The election period begins on the date of the Qualifying

Event and ends on the later of (1) 60 days after the date coverage would have stopped due to the Qualifying Event; or (2) 60 days after the date the Qualified Beneficiary is sent notice of the right to continue coverage under COBRA.

A Covered Employee or Spouse's election of COBRA Continuation Coverage shall be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

If COBRA Continuation Coverage is elected within the election period, coverage shall be reinstated retroactively to the date of the Qualifying Event. If a Qualified Beneficiary waives COBRA Continuation Coverage during the election period, the Qualified Beneficiary may revoke that waiver at any time before the end of the election period and elect COBRA Continuation Coverage retroactive to the date of the Qualifying Event.

(c) Coverage Period. COBRA Continuation Coverage shall begin as of the date of the Qualifying Event and shall continue until the earliest of the following dates:

(1) The date the Qualified Beneficiary first becomes entitled to benefits under Medicare.

(2) 18 months from the date of a Qualifying Event set forth in subsection 2.39(a) or (b).

(3) If a Qualifying Event set forth in subsection 2.39(a) or (b) occurs less than 18 months after the date a Covered Employee becomes entitled to Medicare benefits, the period of coverage for each Qualified Beneficiary other than the Covered Employee shall not terminate before the close of the 36-month period beginning on the date the Covered Employee becomes entitled to Medicare.

(4) If any Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA Continuation Coverage resulting from a Qualifying Event set forth in subsection 2.39(a) or (b), any Qualified Beneficiary may elect an additional 11 months of COBRA Continuation Coverage if:

(i) The disabled Qualified Beneficiary provides the Plan Administrator with the Social Security Administration's determination of disability (i) within 60 days of the later of date the determination is issued and the date the Qualified Beneficiary loses coverage under the Plan as a result of the Qualifying Event, and (ii) within the initial 18 month COBRA Continuation period; and

(ii) The Qualified Beneficiary agrees to pay the increased Covered Person Contribution necessary to continue the coverage for the additional 11 months.

COBRA Continuation Coverage shall automatically end before the additional 11-month period ends on the first day of the month coincident with or next following 30 days from the date that the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

(5) 36 months from the date coverage would have ended due to a Qualifying Event other than that set forth in subsection 2.39(a) or (b).

(6) The date on which the Company ceases to provide any Group Health Plan to any Employee.

(7) If the Qualified Beneficiary fails to make a required Covered Person Contribution, the end of the period for which the last contribution was made.

(8) The date the 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, and such Pre-existing condition limitation is permissible pursuant to HIPAA.

(9) The Separation Date, in the case of a person (A) who (i) is a former employee of the Company or of a Related Employer, of a CPG Related Employer, or of a Columbia Divested Company, and whose last employment with any of such parties prior to termination of employment was with a CPG Related Employer or a Columbia Divested Company (a "CPG Participant"), or (ii) is or was a dependent of a CPG Participant or of an employee of CPG or of a CPG Related Employer; and (B) whose coverage under the Plan ended prior to the Separation Date because of a Qualifying Event.

(d) Multiple Qualifying Events. If after the first Qualifying Event another Qualifying Event occurs, coverage may be continued for an additional period, up to 36 months from the first Qualifying Event.

(e) Notification Requirements. A Qualified Beneficiary shall notify the Plan Administrator within 60 days of the Qualifying Events set forth in subsection 2.39(e) or (f) or of a second Qualifying Event described in subsection 11.05(d). If such notice is not given, the Qualified Beneficiary shall not be eligible for COBRA Continuation Coverage.

(f) Required Contributions. Except as provided in subsection 11.05(g), the Company will not make any contribution toward the cost of COBRA Continuation Coverage. A Qualified Beneficiary electing COBRA Continuation Coverage shall be responsible for a Covered Person Contribution in the amount of 102% of what is calculated to be the total cost of the Coverage Option being continued, or in the case of an individual who is entitled to extended COBRA Continuation Coverage beyond 18 months pursuant to subsection 11.05(c)(4), 150% of what is calculated to be the average cost of the Coverage Option being continued. Premiums for the period of COBRA Continuation Coverage prior to the date of the election will be due 45 days after the COBRA Continuation Coverage is elected. Thereafter, monthly premiums shall be due the first day of the calendar month. There shall be a grace period of 30 days for the payment of regularly scheduled monthly premiums.

(g) Subsidized COBRA. The Company may subsidize all or a portion of the cost of COBRA Continuation Coverage. If the Company so elects, the period of such subsidized coverage shall count towards the COBRA Continuation Coverage period required under this Section.

(h) COBRA-Like Continuation Coverage for Same-Sex Domestic Partners. The Plan will make COBRA-like continuation coverage available to a Same-Sex Domestic Partner who

is a Covered Person (and to a Same-Sex Domestic Partner's Child who is a Covered Person) under circumstances, and subject to the same, terms, conditions and limitations, that would entitle the lawful Spouse or Child of a Participant to elect COBRA continuation coverage. A Same-Sex Domestic Partner and a Child of a Same-Sex Domestic Partner shall have the same notice and other obligations with respect to such continuation coverage as a lawful Spouse or Child of a Participant has with respect to COBRA continuation coverage. For purposes of this COBRA-like continuation coverage, a termination of a same-sex domestic partner relationship will be treated as a divorce.

ARTICLE XII
PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION

12.01 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 Plan must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Covered Employee or Dependent.

12.02 Permitted Uses and Disclosure. The Plan may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plan 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 Plan or the Privacy Standards.

12.03 Disclosures to Company. The Plan 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 Plan 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.

The Company, in its capacity as sponsor of the Plan, agrees to:

(a) not use or further disclose Protected Health Information received from the Plan other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

(c) not use or disclose Protected Health Information received from the Plan for employment-related actions and decisions;

(d) not use or disclose Protected Health Information received from the Plan in connection with any other benefit or employee benefit plan of the Company (except to the extent that such other benefit, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan is a part);

(e) report to the Privacy Official, acting on behalf of the Plan, any use or disclosure of Protected Health Information received from the Plan that is inconsistent with the uses or disclosures authorized by this Section and of which the Company becomes aware;

(f) make available Protected Health Information in accordance with 45 C.F.R. § 164.524 (pertaining to an individual's access to his or her own Protected Health Information) and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(g) make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(i) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("HHS") or to any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with 45 C.F.R. Subchapter C, Subpart E; and

(j) if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The foregoing restrictions do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the Company or any other Employer, acting in their respective capacities as an employer.

12.04 Adequate Separation. There shall be adequate separation between the Plan and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the following employees, classes of employees or other persons under the control of the Company or its affiliates may have access to Protected Health Information created under the Plan:

Privacy Official
Security Official
Members of the Benefits Department
HRIS-Benefits Analyst
Members of the Legal Department
Members of the Internal Audit Department
Members of the Committee
Any other employee of the Company or its affiliates who performs plan administration functions for the Plan and who is designated in writing by the Privacy Official or a member of the Committee as being entitled to access to Protected Health Information.

Access to and use by such individuals shall be restricted to the plan administration functions that the Company and its affiliates perform for the Plan. The Plan or the Company (or an affiliate) has 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 Plan. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plan governing their obligations under the Privacy Standards.

12.05 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 Plan. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

12.06 Special Amendatory Authority. The Privacy Official appointed by the Plan Administrator pursuant to the Privacy Standards shall be authorized to make and execute any amendment to this Article that such Privacy Official deems necessary or appropriate.

ARTICLE XIII
PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

13.01 General. The Department of Health and Human Services has issued Regulations, effective April 20, 2005, that govern the manner in which a group health plan, such as the Plan, must handle Electronic Protected Health Information. "Electronic Protected Health Information" refers to Protected Health Information that is (i) maintained in Electronic Media (as defined in 45 C.F.R. Section 160.103), or (ii) transmitted by Electronic Media.

13.02 Duty of the Plan Sponsor. The Company shall reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted to or by the Company on behalf of the Plan. To this end, the Company shall: (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Company creates, receives, maintains or transmits on behalf of the Plan; (ii) ensure that the adequate separation required by Section 12.04 above is supported by reasonable and appropriate security measures; (iii) ensure that any agent, including a subcontractor, to whom or which the Company provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and (iv) report to the Plan any security incident involving Electronic Protected Health Information of which the Company becomes aware.

ARTICLE XIV
MISCELLANEOUS PROVISIONS

14.01 Assignment of Benefits. A Covered Person may assign benefits to the extent permitted by the Insurer.

14.02 Information To Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

14.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

14.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

14.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

14.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only by the Insurer.

14.07 Misrepresentation. Any material misrepresentation on the part of any Covered Person in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void. Without limiting the generality of the foregoing, a Participant's enrollment of, or failure to disenroll, a person who does not satisfy the eligibility requirements for coverage under the Plan will be deemed to constitute fraud or intentional misrepresentation of a material fact and may result in retroactive termination of benefits, required repayment of any ineligible expenses, and disciplinary action up to and including termination of employment.

14.08 Inadvertent Error. Inadvertent error by the Plan Administrator in the keeping of records or the transmission of any enrollment shall not deprive any Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

14.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the rights of the Company or of any Employer to discipline or terminate an Employee.

14.10 Covered Person's Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Insurer shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect; (2) the Covered Person does not respond to the notice sent to the current address; (3) there are conflicting claims to such payment; or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan,

without interest. Each Participant shall also notify the Plan in writing when any person is no longer eligible for coverage as his or her Dependent hereunder.

14.11 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to offset the overpaid amount against future benefits that are parable or to recover such payments, to the extent of such excess. Without limiting the generality of the foregoing, the Plan shall have the right to recover any amounts it pays in respect of a person who is not an eligible Participant or Dependent.

14.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 14.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

14.13 Severability. In the event any portion of this Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Plan, and the balance of the Plan shall remain in full force and effect.

14.14 Participant Litigation. In any action or proceeding involving the Plan, Covered Persons or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

14.15 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

14.16 Notice. Any notice given under this Plan shall be sufficient if given to the Plan Administrator when addressed to it at its office; if given to the Insurer when addressed to it at its home office; or if given to a Participant when addressed to the Participant at his or her address as it appears on the records of the Plan Administrator.

14.17 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XV
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

15.01 Plan Fully-Insured. The Plan is a fully-insured plan. All contributions related to the Plan are used to pay insurance premiums and related expenses thereunder.

15.02 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Unless expressly provided, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect. To the extent that any applicable collective bargaining agreement imposes a more restrictive requirement regarding Plan eligibility or benefits than is set forth herein, such requirement, as applied solely to those Represented Employees subject to the collective bargaining agreement, is incorporated herein by this reference.

15.03 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

15.04 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Signature page follows.]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 6th day of December, 2017, to be effective as of January 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

FIRST AMENDMENT TO THE NISOURCE VISION PLAN

(As Amended and Restated Effective January 1, 2016)

WHEREAS, NiSource Inc. (the "Company") maintains the NiSource Vision Plan, as amended and restated effective January 1, 2016 (the "Plan"); and

WHEREAS, pursuant to Section 15.02 of the Plan, and subject to Section 15.04 thereof, the NiSource Benefits Committee (the "Committee") has reserved the right to amend the Plan; and

WHEREAS, pursuant to resolutions adopted by the Committee, the Committee desires to amend the Plan, effective as of June 1, 2016, to modify the eligibility provisions and the definitions of "Employee" and "Employer" to clarify the status, during the period from June 1, 2016, to April 30, 2019, of specified participants in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and the Northern Indiana Public Service Company with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019.

NOW, THEREFORE, the Plan is hereby amended, effective as June 1, 2016, as follows:

1. Section 2.22, "**Employee,**" of the Plan is hereby amended to recite in its entirety as follows:

> **2.22** **"Employee"** means an employee of an Employer, if the employee is eligible for coverage under an Applicable SPD. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2. Section 2.23, "**Employer,**" of the Plan is hereby amended to recite in its entirety as follows:

> **2.23** **"Employer"** means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that a group health plan providing vision benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need

for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.23, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014. For the avoidance of doubt, the term "Employer" includes Northern Indiana Public Service Company ("NIPSCO") with respect to an employee employed by NIPSCO in the role of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) (hereinafter, "Damage Prevention Coordinator") during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and NIPSCO with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019, unless such employee was considered an employee covered by a collective bargaining agreement between NIPSCO and a union immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator.

3. Section 3.01, "**Eligibility**," of the Plan is hereby amended to recite in its entirety as follows:

3.01 Eligibility.

(a) Employees. Each Employee of an Employer may be covered under the Plan solely in accordance with the terms of the Applicable SPD. For the avoidance of doubt, no person may be covered under the Plan during such period that he or she is eligible for coverage under the NiSource Inc. Bargaining Unit Employees Vision Plan.

(b) Dependents. A Dependent of a Participant may be covered by the Plan solely in accordance with the terms of the Applicable SPD.

4. All other provisions of the Plan shall remain unchanged.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this First Amendment to the NiSource Vision Plan to be executed on its behalf by one of its members duly authorized, effective as of June 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

NISOURCE
FLEXIBLE BENEFITS PLAN

As Amended and Restated
Effective as of January 1, 2016 (defined herein)

TABLE OF CONTENTS

Page

INTRODUCTION 1

ARTICLE I DEFINITIONS 1
1.01 "Annual Enrollment Period" 1
1.02 "Benefits Administrator" 1
1.03 "Code" 1
1.04 "Columbia Divested Company" 1
1.05 "Committee" 2
1.06 "Company" 2
1.07 "CPG" 2
1.08 "CPG Related Employer" 2
1.09 "CPG Spin-Off" 2
1.10 "CPG Spin-Off Employee" 2
1.11 "Dependent" 2
1.12 "Eligible Employee" 2
1.13 "Employee" 2
1.14 "Employer" 3
1.15 "Enrollment Form" 3
1.16 "ERISA" 3
1.17 "Family" 3
1.18 "Financially Interdependent" 3
1.19 "FMLA" 4
1.20 "FMLA Leave" 4
1.21 "Full-Time Employee" 4
1.22 "Grace Period" 4
1.23 "Health Savings Account" 4
1.24 "HDHP" 4
1.25 "Key Employee" 4
1.26 "NIPSCO" 4
1.27 "Non-Represented" 4
1.28 "Part-Time Employee" 4
1.29 "Participant" 4
1.30 "Plan" 4
1.31 "Plan Administrator" 4
1.32 "Plan Year" 4
1.33 "Qualified Beneficiary" 4
1.34 "Qualifying Event" 4
1.35 "Represented" 4
1.36 "Related Employer 4
1.37 "Salary Reduction Contributions" 5
1.38 "Same-Sex Domestic Partner" 5
1.39 "Separation Date" 5
1.40 "Special Enrollment Period" 5
1.41 "Spouse" 5
1.42 "Status Change" 6
1.43 "Supplements" 7
1.44 "USERRA" 7

1.45 "Welfare Plan" 7

ARTICLE II ELIGIBILITY AND PARTICIPATION 7
2.01 Eligibility 7
2.02 Participation 7
2.03 Termination of Participation 7
2.04 Reinstatement of a Former Participant 7

ARTICLE III PARTICIPATION AND SALARY REDUCTION CONTRIBUTIONS 8
3.01 Coverage Options 8
3.02 Enrollment and Salary Reduction Contributions 8
3.03 Change or Discontinuance of Salary Reduction Contributions 9
3.04 Contributions During Leave 11
3.05 Failure to Elect 11
3.06 Special Enrollment Periods. 12
3.07 Military Leave 13
3.08 Effect of Existing Enrollment 13
3.09 Nondiscrimination and Limitation on Contributions 13

ARTICLE IV UTILIZATION OF SALARY REDUCTION CONTRIBUTIONS 14
4.01 Utilization of Salary Reduction Contributions 14
4.02 Participant Cost of Medical Plan Coverage Option 14
4.03 Participant Cost of Dental Plan Coverage Option 14
4.04 Participant Cost of Vision Plan Coverage Option 14
4.05 Participant Cost of Long-Term Disability Plan Coverage Option 14
4.06 Participant Cost of Life Insurance Plan Coverage Option 14
4.07 Medical Expense Reimbursement Option 14
4.08 Dependent Care Expense Option 14
4.09 Health Savings Account Option 14

ARTICLE V PAYMENT OF BENEFITS 14
5.01 Payment of Benefits 14
5.02 Designation of Beneficiaries 14
5.03 Facility of Payment 15

ARTICLE VI ADMINISTRATION 15
6.01 The Plan Administrator 15
6.02 Rules of Administration 15
6.03 Examination of Records 16
6.04 Reliance on Tables, Etc 16
6.05 Nondiscriminatory Exercise of Authority 16
6.06 Indemnification of Plan Administrator 16
6.07 Limitation on Liability 16
6.08 Appointment of Benefits Administrator 16

ARTICLE VII CLAIMS PROCEDURE 16
7.01 Claims for Benefits Payable Under Supplements A-F 16
7.02 Claims for Benefits Payable Under Supplement G. 22
7.03 Other Claims 24
7.04 Legal Actions 24

ARTICLE VIII PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION 24
8.01 General 24
8.02 Permitted Uses and Disclosure 24
8.03 Disclosures to Company 24
8.04 Adequate Separation 25
8.05 Unauthorized Use or Disclosure 26
8.06 Special Amendatory Authority 26

ARTICLE IX PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION 26
9.01 General 26
9.02 Duty of the Plan Sponsor 26

ARTICLE X AMENDMENT OR TERMINATION OF THE PLAN 26
10.01 Plan Amendment or Modification 26
10.02 Plan Termination 26
10.03 Effective Date of Amendment or Termination 27

ARTICLE XI MISCELLANEOUS PROVISIONS 27
11.01 Information To Be Furnished 27
11.02 Right to Continued Employment 27
11.03 Plan Not Contract 27
11.04 No Limitation of Management Rights 27
11.05 Participant Responsibilities 27
11.06 Spendthrift Provision 27
11.07 Written Communication 27
11.08 Limitation of Rights 27
11.09 Fiduciaries 28
11.10 Severability 28
11.11 Construction 28
11.12 Governing Law and Venue 28
11.13 Funding 28
11.14 No Guarantee 28
11.15 Participant Litigation 28
11.16 Mistake of Fact 29
11.17 Withholding for Taxes 29
11.18 Right of Recovery 29
11.19 Costs of Administering the Plan 29
11.20 Discrimination Rules 29
11.21 Extension of Plan to Related Employers 29

SUPPLEMENT A Participant Cost of Medical Plan Coverage Option A-1

SUPPLEMENT B Participant Cost of Dental Plan Coverage Option B-1

SUPPLEMENT C Participant Cost of Vision Plan Coverage Option C-1

SUPPLEMENT D Participant Cost of Long-Term Disability Plan Coverage Option D-1

SUPPLEMENT E Participant Cost of Life Insurance Coverage Option E-1

SUPPLEMENT F Medical Expense Reimbursement Option F-1

SUPPLEMENT G Dependent Care Expense Option G-1

SUPPLEMENT H Health Savings Account Option H-1

INTRODUCTION

Columbia Energy Group established and maintained the Columbia Energy Group Cafeteria Plan. The Columbia Energy Group Cafeteria Plan was broadened to include coverage for the former participants and beneficiaries of one or more cafeteria plans sponsored by NiSource Inc. (the "Company") or an affiliate, and was renamed the NiSource Flexible Benefits Plan, effective as of January 1, 2004, and as of such date, has been sponsored and maintained by the Company. In 2005, the Company adopted several new health care options and the Plan was amended and restated, effective as of January 1, 2006, to incorporate such options. Effective January 1, 2008, the Plan was amended and restated and became a component welfare plan of the NiSource Welfare Benefits Program; provided, however, that only Supplement F described herein is subject to ERISA. The Plan was further amended and restated effective as of January 1, 2011, as of January 1, 2013, as of January 1, 2014, as of January 1, 2015, and as of July 1, 2015. This is an amendment and restatement of the Plan effective as of January 1, 2016.

The purpose of the Plan is to permit eligible Employees of an Employer to choose between cash and the benefits described in the Supplements attached hereto. The Plan is maintained for the exclusive benefit of Eligible Employees and is intended to meet the requirements of, and to constitute, a cafeteria plan under Section 125 of the Code, an accident and health plan under Sections 105 and 106 of the Code with respect to the Options described in Supplements A-F, a dependent care assistance program under Section 129 of the Code with respect to the Dependent Care Expense Option described in Supplement G, and a health savings account funding method under Sections 106, 125 and 223 of the Code with respect to the Health Savings Account Option described in Supplement H.

ARTICLE I
DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context. A pronoun or adjective in the masculine gender includes the feminine gender and the singular includes the plural, unless the context clearly indicates otherwise.

1.01 **"Annual Enrollment Period"** means the period established by the Company each year, during which time an Eligible Employee may enroll for coverage or modify a prior enrollment to be effective for the following Plan Year.

1.02 **"Benefits Administrator"** means the person, persons, entity or entities appointed by the Plan Administrator pursuant to Section 6.08.

1.03 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

1.04 **"Columbia Divested Company"** means any one of the following companies that previously was affiliated with a Related Employer: Columbia Energy Services Corp., Columbia Propane Corporation, Columbia Electric Corporation, Columbia LNG Corporation, Energy.com Corporation, Columbia Trans Communications, Commonwealth Propane, Columbia Propane LP, Columbia Petroleum Corporation, Columbia Natural Resources Inc., Hawg Hauling & Disposal Inc., Coal Gas, CS-42, Gas Development, New York Gas & Elec, Pittsburgh Market Division and Columbia Gas of West Virginia.

1.05 **"Committee"** means the NiSource Benefits Committee and its predecessor, the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

1.06 **"Company"** means NiSource Inc., a Delaware Corporation.

1.07 **"CPG"** means Columbia Pipeline Group, Inc., a Delaware corporation.

1.08 **"CPG Related Employer"** means, on and after the Separation Date, (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes CPG; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with CPG; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes CPG.

1.09 **"CPG Spin-Off"** means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG

1.10 **"CPG Spin-Off Employee"** means an employee of CPG or its affiliates who was covered under this Plan immediately prior to the Separation Date and who became ineligible for such coverage in connection with the CPG Spin-Off.

1.11 **"Dependent"** means:

(a) With regard to benefits provided under Supplements A-E, "dependent" as defined under the Options identified therein;

(b) With regard to benefits provided under Supplement F, "dependent" as defined in Code Section 105(b);

(c) With regard to benefits provided under Supplement G, "dependent" means a "qualifying individual" as defined in Code Section 21(b);

(d) With regard to benefits provided under Supplement H, "dependent" as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and

(e) A child who is recognized under any court order, including a Qualified Medical Child Support Order (as defined in Section 609 of ERISA) as having a right to coverage under a Supplement as a Dependent.

Notwithstanding any other provision of the Plan, effective January 1, 2017, neither a Same-Sex Domestic Partner nor a Same-Sex Domestic Partner's child shall be a "Dependent" for purposes of the Plan.

1.12 **"Eligible Employee"** means an Employee eligible to participate in some or all levels of coverage under the Plan pursuant to Section 2.01.

1.13 **"Employee"** means a regular or temporary Full-Time or Part-Time Non-Represented employee of an Employer or a regular Full-Time or Part-Time Represented employee of an Employer whose collective bargaining agreement provides for his or her eligibility in the Plan. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any

other way found to be a common-law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

1.14 **"Employer"** means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that one or more welfare benefits plans providing benefits of the type described in any of the Supplements is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan or plans are not included as part of the Welfare Plans for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 1.14, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

1.15 **"Enrollment Form"** means the form or method of communication approved by the Plan Administrator that is used for enrollment purposes as provided in Section 3.03. An Enrollment Form shall include an agreement to make or not to make Salary Reduction Contributions.

1.16 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

1.17 **"Family"** means an Employee and such Employee's Spouse and Dependents.

1.18 **"Financially Interdependent"** means that a Participant and another person satisfy any two of the following conditions:

(a) the Participant designates such other person as the Participant's beneficiary for employer-sponsored retirement or life insurance benefits;

(b) the Participant designates such other person as the primary beneficiary under the Participant's will;

(c) the Participant designates such other person as the Participant's attorney-in-fact under a durable power of attorney for health care;

(d) the Participant and such other person have a common ownership or leasehold interest in real property;

(e) the Participant and such other person have joint bank or credit accounts or joint investments; or

(f) the Participant and such other person have joint liability for a mortgage, lease or loan.

1.19 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

1.20 **"FMLA Leave"** means a period of absence taken under the FMLA.

1.21 **"Full-Time Employee"** means an Employee characterized by an Employer as a full-time employee who regularly works 40 or more hours per week.

1.22 **"Grace Period"** means the period during which a Participant may incur additional expenses to be reimbursed under Supplement F using Salary Reduction Contributions from the immediately preceding Plan Year. Such Grace Period shall begin on January 1 and end on March 15.

1.23 **"Health Savings Account"** means a health savings account within the meaning of Code Section 223.

1.24 **"HDHP"** means a high deductible health plan within the meaning of Code Section 223.

1.25 **"Key Employee"** means any person who is a key employee, as defined in Section 416(i)(1) of the Code.

1.26 **"NIPSCO"** means Northern Indiana Public Service Company.

1.27 **"Non-Represented"** means a Full-Time or Part-Time Employee who is not covered by a collective bargaining agreement between an Employer and a union.

1.28 **"Part-Time Employee"** means an Employee characterized by an Employer as a part-time employee who regularly works ten or more, but less than 40, hours per week.

1.29 **"Participant"** means any individual who participates in the Plan in accordance with the eligibility provisions of Article II and one or more Supplements.

1.30 **"Plan"** means the NiSource Flexible Benefits Plan as set forth herein, together with any and all amendments and supplements hereto.

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

1.32 **"Plan Year"** means the period beginning on January 1 and ending on December 31.

1.33 **"Qualified Beneficiary"** means "qualified beneficiary" as defined in Section 4980B(g)(1) of the Code.

1.34 **"Qualifying Event"** means a "qualifying event" as defined in Section 4980B(f)(3) of the Code.

1.35 **"Represented"** means a Full-Time or Part-Time Employee who is covered by a collective bargaining agreement between an Employer and a union.

1.36 **"Related Employer"** means (i) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (ii) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (iii) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

1.37 **"Salary Reduction Contributions"** means the elective contributions made in accordance with Article III and used to provide benefits under the Supplements.

1.38 **"Same-Sex Domestic Partner"** means, with respect to a Participant, a person of the same sex as the Participant, if the Participant and such person satisfy the requirements of paragraph (a) or each of the requirements of paragraph (b) below:

(a) Such person is the Participant's registered domestic partner, or is a party to a civil union with the Participant, under the laws of the Participant's state of residence; or

(b) The Participant and such person

(1) are both age 18 or older and competent to enter into a legal contract;

(2) have shared for at least 12 months (and continue to share) the same principal residence, are jointly responsible for each other's common welfare, and are Financially Interdependent;

(3) share a committed personal relationship and are not related to one another in a way that would prohibit marriage, civil union or domestic partnership between two persons in the Participant's state of residence;

(4) reside in a state that, prior to June 26, 2015, did not recognize or permit same-sex marriage, domestic partner registration or civil union;

(5) are not currently married to, a party to a civil union with, or the domestic partner, of any other person;

(6) intend that their same-sex domestic partnership be of unlimited duration; and

(7) do not have a relationship that is primarily for the purpose of obtaining benefits under an employer-sponsored benefit program.

Notwithstanding the foregoing, for any insured benefit option, a person shall not be a Same-Sex Domestic Partner if he is otherwise ineligible for coverage under the terms of the certificate of coverage, group insurance policy or other governing document for such benefit option.

From time to time, a Participant may be required to confirm orally, electronically or in writing, in a manner prescribed by the Plan Administrator, that the Participant and his or her Same-Sex Domestic Partner satisfy the foregoing eligibility requirements.

1.39 **"Separation Date"** means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

1.40 **"Special Enrollment Period"** means the enrollment periods offered under subsections 3.06 (a), (b) and (c).

1.41 **"Spouse"** means a person who is treated as a spouse under the Code. Notwithstanding the above, for purposes of the Dependent Care Expense Option described in Supplement G, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the

Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

1.42 "Status Change" means any of the following:

(a) Legal Marital Status. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(b) Number of Dependents. Events that change an Employee's number of Dependents, including birth, adoption, placement for adoption (as defined in Treasury Regulations under Code Section 9801), or death of a Dependent.

(c) Employment Status. A termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite that changes the employment status of an Employee, a Spouse or other Dependent, or any other change in the employment status of an Employee, a Spouse or other Dependent that makes such individual eligible or ineligible for coverage under the Plan (such as switching from full-time to part-time status or from salaried to hourly-paid).

(d) Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to marriage, attainment of age, student status, or any similar circumstance as provided in the Plan.

(e) Residence. A change in the place of residence of an Employee, a Spouse or other Dependent.

(f) Other Permissible Events. Any other event that the Plan Administrator or a member of the Committee determines to be a permissible Status Change under the Code or any regulation, ruling or release issued thereunder. Such determination shall be (1) consistent with the terms of any applicable Welfare Plan; (2) made in a uniform and non-discriminatory manner; and (3) subject to the claims procedures set forth in Article VII.

As used in this definition, and subject to the immediately following paragraph, the term "Dependent" shall include only those Dependents described in Section 1.11 above who would be considered a "dependent" for purposes of Code Section 125, the regulations thereunder, and Internal Revenue Service Notice 2010-38, as such statutory provision, regulations or guidance may be amended or modified from time to time.

Solely for purposes of this definition, and only for the period beginning January 1, 2013, and ending on December 31, 2016, a "Spouse" will be deemed to include a Participant's Same-Sex Domestic Partner, "marriage" will be deemed to include the establishment of a Same-Sex Domestic Partner relationship, "divorce" will be deemed to include the termination of a Same-Sex Domestic Partner relationship, and the term "Dependent" will be deemed to include a Same-Sex Domestic Partner and a Same-Sex Domestic Partner's "child," as defined under the Options identified in Supplements A-E; provided, however, that notwithstanding any other provision of the Plan, no change or discontinuance of Salary Reduction Contributions involving a Same-Sex Domestic Partner or any such "child" shall be made if such change would violate requirements of the Code or any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee, in their sole discretion, or would violate the requirements of any insurer with respect to benefits described in any Supplement hereunder.

1.43 **"Supplements"** means Supplements A through H attached hereto.

1.44 **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

1.45 **"Welfare Plan"** means each of the NiSource Consolidated Flex Medical Plan, the NiSource Dental Plan, the NiSource Vision Plan, the NiSource Long-Term Disability Plan, the NiSource Life Insurance Plan, the NiSource Inc. Bargaining Unit Employees Vision Plan, and the Northern Indiana Public Service Company Employee Life Insurance Plan.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.01 **Eligibility**. Each Employee shall be eligible to participate in the Plan subject to the following limitations:

(a) No Represented Employee of Northern Indiana Public Service Company shall be considered eligible to participate in Supplement F or Supplement G unless he or she is a regular, Full-Time Employee and a member of United Steelworkers of America Local 12775 or 13796.

(b) An Employee may participate in Supplement H only if he or she is covered by an HDHP offered by the Company; is not covered by any other health plan that is not an HDHP; is not enrolled in Medicare Part A or Part B; and may not be claimed as a dependent on another person's Federal tax return.

(c) No Employee may participate in Supplements F and H at the same time.

(d) No Part-Time Employee may participate in Supplement D.

(e) Any other eligibility limitation set forth in the Supplements.

2.02 **Participation**. Subject to the provisions of Section 2.01, an Eligible Employee shall become a Participant when he or she properly enrolls for coverage in accordance with Article III.

2.03 **Termination of Participation.** Subject to the coverage continuation provisions of the Supplements, participation during a Plan Year shall terminate on the earliest of:

(a) The date on which the Plan terminates;

(b) The last day of the month in which an Employee ceases to be an Employee for any reason, including without limitation as a result of the Employee's employer no longer being a Related Employer; or

(c) With respect to a Dependent, the date on which the Dependent ceases to be a Dependent.

2.04 **Reinstatement of a Former Participant**. A former Participant shall become a Participant again if and when he or she meets the eligibility requirements of Section 2.01 and properly enrolls under Section 3.02.

ARTICLE III
PARTICIPATION AND SALARY REDUCTION CONTRIBUTIONS

3.01 Coverage Options. Subject to the eligibility provisions of Section 2.01, each Participant may choose under this Plan to have a portion of his or her compensation applied toward the cost of coverage available to the Participant under the Supplements.

3.02 Enrollment and Salary Reduction Contributions.

(a) General. During the Annual Enrollment Period, the Plan Administrator shall provide each Eligible Employee with an opportunity to continue, revise or revoke his or her existing enrollment. During such Annual Enrollment Period, each person who has newly become an Eligible Employee, each Eligible Employee who is not a Participant, and each Participant shall elect whether he or she desires to make Salary Reduction Contributions to the Plan for the Plan Year. Such enrollment also shall specify the allocation of his or her Salary Reduction Contributions among the various Supplements. In addition, each person upon newly becoming an Eligible Employee shall have a period of 31 days within which to elect to make Salary Reduction Contributions to the Plan. No enrollment shall be effective for a Plan Year unless it is filed with the Plan Administrator (a) within 31 days following the date a person becomes an Eligible Employee, (b) during the Annual Enrollment Period, or (c) within 31 days after an event allowing a change in enrollment under Section 3.03.

Notwithstanding the foregoing, an Eligible Employee who participates in Supplement H shall be permitted to elect, continue, revise or revoke his or her Salary Reduction Contributions under Supplement H on a monthly basis. Any changes to an Eligible Employee's Salary Reduction Contributions under Supplement H shall be made on a prospective basis.

(b) Salary Reduction Contributions. Salary Reduction Contributions for each Plan Year will be made through periodic payroll withholding payments, beginning with the first regularly scheduled pay day for such Plan Year for which a Participant's enrollment is filed. The Plan Administrator shall establish rules and regulations with respect to enrollment and Salary Reduction Contributions hereunder in accordance with Sections 105, 106, 125, 129 and 223 of the Code and Regulations thereunder. The maximum amount of Salary Reduction Contributions available to any Employee under the Plan is equal to the sum of the those amounts, for each Supplement hereunder, that represent the highest Participant cost of coverage that may be elected under each such Supplement.

(c) Forfeitures.

(1) Any Salary Reduction Contributions allocated by a Participant that are not used to satisfy the Participant's costs under Supplements A-E for a Plan Year shall be forfeited as of the end of such Plan Year and shall be used to reduce administrative expenses of the Plan for subsequent Plan Years.

(2) A Participant's Salary Reduction Contributions that are not used to provide Plan benefits under Supplement F for a Plan Year or the Grace Period, shall not at any time be returned or repaid to the Participant, but shall be forfeited and used to reduce administrative expenses of the Plan in subsequent Plan Years.

(3) A Participant's Salary Reduction Contributions that are not used to provide Plan benefits under Supplement G for a Plan Year shall not at any time be returned or repaid to the Participant, but shall be forfeited and used to reduce administrative expenses of the Plan in subsequent Plan Years.

3.03 **Change or Discontinuance of Salary Reduction Contributions**. An Eligible Employee may not revise any enrollment election, including the rate of his or her Salary Reduction Contributions, or discontinue making Salary Reduction Contributions during a Plan Year, except as follows:

(a) An Eligible Employee's Salary Reduction Contributions will automatically terminate as of the date his or her Plan participation terminates in accordance with Section 2.03.

(b) An Eligible Employee may revoke any prior enrollment election in Supplements A-G and file a new enrollment election for the balance of a Plan Year on account of and consistent with a Status Change, provided such change in election is permitted by the terms of plan documents for the applicable Welfare Plans described in such Supplements. An Eligible Employee's revocation and new enrollment election will be consistent with a Status Change if, and only if (i) the Status Change results in the Eligible Employee, Spouse or other Dependent gaining or losing eligibility under Supplements A-C or F, a Welfare Plan, or an accident or health plan of the Spouse or Dependent's employer or, with respect to Supplement G, the Status Change affects expenses described in Code Section 129 (including employment-related expenses as defined in Code Section 21(b)(2)), and (ii) the election change corresponds with that gain or loss of coverage or effect upon expenses. Notwithstanding the foregoing, the consistency requirement will apply only to the extent it is required under Code Section 125 and the Regulations thereunder.

(c) An Eligible Employee may revoke an election with respect to Supplements A-E and file a new enrollment election with respect thereto for the balance of a Plan Year, and the Plan may automatically make a prospective increase (or decrease) in an Eligible Employee's Salary Reduction Election, if the cost of a Welfare Plan changes during a Plan Year, and under the terms of the underlying plan or Supplements A-E the Participant is required to make a corresponding change in his or her payments under such Welfare Plan. In addition, the Plan may automatically make a prospective decrease in an Eligible Employee's Salary Reduction Election with respect to Supplements A-E as a result of any event that causes a Participant or Dependent to lose eligibility for any Welfare Plan described in such Supplements.

(d) An Eligible Employee may revoke an existing election with respect to Supplements A-E or G and file a new enrollment election with respect thereto for the balance of a Plan Year if the cost of a Welfare Plan significantly increases or decreases during a Plan Year. Any new enrollment election must correspond with such increase or decrease in cost. For example, an Eligible Employee may commence participation in any one of Supplements A-E or G if the cost of such Supplement (or an option thereunder) significantly decreases. In addition, if any one of Supplements A-E or G (or an option thereunder) significantly increases in cost during a Plan Year, an Eligible Employee may revoke an election with respect to an option offered under such Supplement and, in lieu thereof, either receive on a prospective basis coverage under another option offered under such Supplement that provides similar coverage, or drop coverage if no other option providing similar coverage is available.

(e) An Eligible Employee may revoke an election with respect to Supplements A-E or G and file a new enrollment election with respect thereto for the balance of a Plan Year if the coverage under an underlying Welfare Plan under Supplements A-E or G is significantly curtailed or ceases during a period of coverage. In the case of a significant curtailment without loss of coverage, an Eligible Employee may revoke an election with respect to an option offered under a Supplement and, in lieu thereof, either receive on a prospective basis coverage under another option offered under such Supplement that provides similar coverage. In the case of a significant curtailment with loss of coverage, an Eligible Employee may revoke an election with respect to an option offered under a Supplement and, in lieu thereof, either receive on a prospective basis coverage under another option offered under such Supplement that provides similar coverage, or drop coverage if no other option providing similar coverage is available.

(f) An Eligible Employee may revoke an enrollment election with respect to Supplements A-E and file a new enrollment election with respect thereto for the balance of a Plan Year if the Plan adds a new benefit or other coverage option or the terms of a benefit offered under Supplements A-E are significantly improved during a period of coverage.

(g) An Eligible Employee may revoke any prior enrollment election and file a new enrollment election for the balance of a Plan Year on account of the entry of a court judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (as defined in section 609 of ERISA)) that requires coverage under Supplements A-F or H for a child.

(h) An Eligible Employee may revoke any prior enrollment election with respect to a Welfare Plan providing accident or health plan coverage and file a new enrollment election for the balance of a Plan Year if the Eligible Employee, his or her Spouse or other Dependent becomes enrolled under Medicare Parts A, B, or C, or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(i) An Eligible Employee may revoke any prior enrollment election and file a new enrollment election for the balance of a Plan Year on account of and corresponding with a change made under another employer's plan if (i) the other cafeteria plan or qualified benefits plan permits Participants to make an election that is consistent with the permitted election change rules under Section 125 of the Code and the regulations issued thereunder, or (ii) the Plan permits Eligible Employees to make an election for a period of coverage that is different from the period of coverage under the other employer's cafeteria plan or qualified benefits plan.

(j) A Participant may revoke his or her elections under Supplements A-C and F on account of an unpaid FMLA Leave. When he or she returns from unpaid FMLA Leave after having revoked health benefit elections on account of taking FMLA Leave, he or she may have health benefit elections reinstated on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA.

(k) An Eligible Employee may revise or revoke an election under Supplement H as provided in Section 3.02(a). Such change will be effective on a prospective basis only.

With respect to an event described in (b), (c), (d), (e), (f), (h) or (i), a Participant's revocation and new enrollment will be effective as of the date it is approved by the Plan. The Participant must

file a new Enrollment Form pursuant to this Section with the Plan within 31 days after the occurrence of the applicable event described in this Section. For purposes of this Section, any election by a Participant to change the apportionment of his or her Salary Reduction Contributions among the various benefits provided for by the Supplements will be considered a revision of the rate of his or her Salary Reduction Contributions.

Notwithstanding any provision of this Section 3.03 or of Section 3.06, no change in enrollment election or Salary Reduction Contribution in respect of an event involving a Same-Sex Domestic Partner or a Same-Sex Domestic Partner's "child," as defined under the Options identified in Supplements A-E shall be made if such change would violate requirements of the Code or of any regulations or other guidance issued thereunder, as determined by the Plan Administrator or its designee in their sole discretion, or would violate the requirements of an insurer with respect to benefits described in any Supplement hereunder.

3.04 Contributions During Leave. With respect to a Participant who goes on an unpaid leave of absence, contributions required or permitted to be made by him or her under the Plan may be made by one of the following methods, as agreed between the Employee on leave and the Plan Administrator before the commencement of the leave of absence or the applicable coverage period:

(a) Contributions may be made by the Employee on leave on an after-tax basis; or

(b) Contributions may be made by the Employee on leave by pre-payment on a pre-tax basis with respect to the same Plan Year during which the leave begins; or

(c) Contributions may be advanced by the Employer on behalf of an Employee on leave and re-paid by the Participant when he or she returns from leave on either a pre-tax basis with respect to the same Plan Year during which the leave ends or on an after-tax basis.

However, in no event will the Plan be operated in a manner that enables an Employee on an unpaid leave of absence to defer compensation from one Plan Year to a subsequent Plan Year.

3.05 Failure to Elect. Subject to Section 3.08 below, an Eligible Employee who fails to properly enroll in Supplements A-G within 31 days following the date such Employee becomes an Eligible Employee or during the Annual Enrollment Period shall be deemed to have elected not to participate in the Plan for that Plan Year and shall be deemed to have elected to receive his or her full compensation in cash, and no Salary Reduction Contributions will be made on his or her behalf under the Plan until an enrollment to the contrary is timely filed with the Plan Administrator during an Annual Enrollment Period, or such Employee elects to participate pursuant to Section 3.03.

An Eligible Employee who fails to elect, or elects not to use, Salary Reduction Contributions to pay for the Participant cost of a Medical Option or Dental Option under Supplement A or Supplement B may be entitled to an opt-out credit as provided by the terms of such Option.

An Eligible Employee shall be permitted to elect, revise or revoke Salary Reduction Contributions under Supplement H on a monthly basis. Any election of or changes to an Eligible Employee's Salary Reduction Contributions under Supplement H shall be made on a prospective basis.

3.06 Special Enrollment Periods.

(a) Loss of Coverage. If an Eligible Employee declined Plan participation in Supplement A for himself or herself, or declined coverage for his or her Spouse or Dependent, because he or she or the Spouse or Dependent was covered under another Group Health Plan or had other health insurance coverage when the Eligible Employee declined coverage, such Eligible Employee may enroll in Supplement A and make any necessary Salary Reduction Contribution change during the Special Enrollment Period provided under this subsection if the Eligible Employee, Spouse or Dependent loses the other coverage for reasons including, but not limited to:

(1) Loss of eligibility of coverage (other than failure to pay premiums or termination of coverage for cause);

(2) Termination of employer contributions under the other plan; or

(3) Exhaustion of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

If requested, such Eligible Employee must have stated when he or she declined coverage under the Plan that he or she declined coverage because of such other coverage.

The Special Enrollment Period offered pursuant to this subsection shall begin on the date the other coverage was lost and shall expire 31 days thereafter. Accordingly, to become covered under this subsection, the Eligible Employee shall properly enroll for coverage within such Special Enrollment Period. If the Eligible Employee so properly enrolls, coverage under this subsection shall be effective as of the date such enrollment is approved by the Plan.

For purposes of this subsection, "Group Health Plan" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

(b) Newly Acquired Dependent. If an Eligible Employee or Qualified Beneficiary acquires a Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, the Eligible Employee or Qualified Beneficiary may enroll in Supplement A and make any necessary Salary Reduction Contribution change during the Special Enrollment Period provided under this subsection.

The Special Enrollment Period offered pursuant to this subsection shall begin on the date of the marriage, birth, adoption or placement for adoption, and shall expire 31 days thereafter. Accordingly, to become covered under this subsection, the Eligible Employee or Qualified Beneficiary shall properly enroll in coverage within such Special Enrollment Period. If the Eligible Employee or Qualified Beneficiary so properly enrolls, coverage under this subsection shall be effective as of the beginning of the Special Enrollment Period, in the case of the acquisition of a Dependent by reason of birth, adoption or placement for adoption, and on the date such enrollment is approved by the Plan, in all other cases.

Solely for purposes of this subsection (b), and only for the period beginning January 1, 2013, and ending on December 31, 2016, the term "Spouse" shall include a Same-Sex Domestic Partner and the term "marriage" shall include the establishment of a Same-Sex Domestic Partner relationship.

(c) Gain or Loss of Eligibility for Medicaid or State Child Health Plan Coverage. Effective April 1, 2009, an Eligible Employee who has not enrolled for coverage under Supplement A (or who has not enrolled his or her Dependent for coverage under Supplement A) may enroll in Supplement A and make any necessary Salary Reduction Contribution changes during the Special Enrollment Period provided under this subsection if the Eligible Employee (or his or her eligible Dependent) either

(1) Was covered under a Medicaid plan or under a State child health plan under title XXI of the Social Security Act of 1965, as amended, and coverage of the Eligible Employee or Dependent under such a plan was terminated as a result of loss of eligibility for such coverage; or

(2) Becomes eligible for assistance, with respect to coverage under Supplement A, under a Medicaid plan or under a State child health plan under title XXI of the Social Security Act of 1965, as amended, (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Special Enrollment Period offered pursuant to this subsection shall begin on the date coverage under the Medicaid plan or State child health plan was terminated or the date the Eligible Employee or Dependent is determined to be eligible for assistance with respect to coverage under Supplement A, and shall expire 60 days thereafter. Accordingly, to become covered under this subsection, the Eligible Employee shall properly enroll for coverage within such Special Enrollment Period. If the Eligible Employee so properly enrolls, coverage under this subsection shall be effective as of the date such enrollment is approved by the Plan.

3.07 Military Leave. With respect to Supplements A, B, C or F, an Eligible Employee may revoke any prior enrollment election, file a new enrollment election for the balance of a Plan Year, and make any necessary Salary Reduction Contribution change upon leaving employment for military service or subsequent reemployment after military service, in accordance with USERRA.

3.08 Effect of Existing Enrollment. With respect to Supplements A-E, a Participant's enrollment shall remain in effect from Plan Year to Plan Year unless changed by such Participant in accordance with the terms of the Plan. With respect to Supplements F-H, a Participant's enrollment for a particular Plan Year shall expire at the end of such Plan Year.

3.09 Nondiscrimination and Limitation on Contributions. If at any time the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirements under the Code, the Plan Administrator may take such action as it deems appropriate to assure compliance with such requirement. Such action may include, without limitation, a modification of elections by Participants or excluding certain Participants from coverage under the Plan. No election shall become valid to the extent it shall cause a Participant's contributions to a plan maintained by an Employer that is qualified under Code Section 401(a) to exceed the limits placed on contributions by Code Section 415.

ARTICLE IV
UTILIZATION OF SALARY REDUCTION CONTRIBUTIONS

4.01 **Utilization of Salary Reduction Contributions**. Salary Reduction Contributions shall be used to purchase benefits in accordance with this Article IV. Each Participant shall allocate his or her Salary Reduction Contributions for a Plan Year in his or her enrollment filed in accordance with Article III.

4.02 **Participant Cost of Medical Plan Coverage Option.** Salary Reduction Contributions may be applied by a Participant to provide for the Participant Cost of Medical Plan Coverage Option set forth in Supplement A.

4.03 **Participant Cost of Dental Plan Coverage Option**. Salary Reduction Contributions may be applied by a Participant to provide for the Participant Cost of Dental Plan Coverage Option set forth in Supplement B.

4.04 **Participant Cost of Vision Plan Coverage Option.** Salary Reduction Contributions may be applied by a Participant to provide for the Participant Cost of Vision Plan Coverage Option set forth in Supplement C.

4.05 **Participant Cost of Long-Term Disability Plan Coverage Option**. Salary Reduction Contributions may be applied by a Participant to provide for the Participant Cost of Long-Term Disability Plan Coverage Option set forth in Supplement D.

4.06 **Participant Cost of Life Insurance Plan Coverage Option**. Salary Reduction Contributions may be applied by a Participant to provide for the Participant Cost of Life Insurance Plan Coverage Option set forth in Supplement E.

4.07 **Medical Expense Reimbursement Option**. Salary Reduction Contributions may be applied by a Participant to provide for the Medical Expense Reimbursement Option set forth in Supplement F.

4.08 **Dependent Care Expense Option.** Salary Reduction Contributions may be applied by a Participant to provide for the Dependent Care Expense Option set forth in Supplement G.

4.09 **Health Savings Account Option**. Salary Reduction Contributions may be applied by a Participant to provide for the Health Savings Account Option set forth in Supplement H.

ARTICLE V
PAYMENT OF BENEFITS

5.01 **Payment of Benefits**. Benefits payable under the Plan shall be paid as soon as practicable in such amounts, at such times, in such manner and form, and to such persons, as shall be determined in accordance with the Plan.

5.02 **Designation of Beneficiaries**. Each Participant, Spouse or covered Dependent from time to time may name any person (who may be named concurrently, contingently or successively) to whom the Participant's, covered Spouse's or covered Dependent's benefits under the Plan are to be paid if the Participant's Spouse or covered Dependent dies before he or she receives all of such benefits. Each such beneficiary designation will revoke all prior designations by the Participant, Spouse or covered Dependent, shall not require the consent of any previously named beneficiary, shall be in a form prescribed by the Plan Administrator, and shall be effective only when filed

with the Plan Administrator during the Participant's, Spouse's or covered Dependent's lifetime. If a Participant, Spouse or covered Dependent fails to designate a beneficiary before his or her death, as provided above, or if the designated beneficiary dies before the date of the Participant's, Spouse's or covered Dependent's death or before complete payment of the Participant's, Spouse's or covered Dependent's benefits, the Plan Administrator shall pay such benefits to the Participant's or covered Dependent's Spouse, or if no Spouse is living, to his or her lawful descendants per stirpes, or if none are living, to the legal representative of the estate of the Participant, Spouse or covered Dependent, or if none is appointed within 6 months after the date of his or her death, to his or her heirs under the laws of the state in which he or she is domiciled at the date of his or her death.

5.03 **Facility of Payment**. When a person entitled to benefits under the Plan is legally disabled or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative or to a relative or friend of such person for such person's benefit, or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any such payment shall be a full and complete discharge of any liability for such payment under the Plan.

ARTICLE VI
ADMINISTRATION

6.01 **The Plan Administrator**. The Plan Administrator shall control and manage the operation and administration of the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

6.02 **Rules of Administration**. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To make factual determinations regarding any issue arising under the Plan;

(d) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(e) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan;

(f) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing;

(g) To approve any change of election under the provisions of the Plan;

(h) To receive and evaluate reports of the providers of benefits under the Supplements; and

(i) To receive and evaluate records to ensure contributions are allocated in accordance with the Participant's election.

6.03 Examination of Records. The Plan Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

6.04 Reliance on Tables, Etc. In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the Benefits Administrator, accountants, counsel or other experts employed or engaged by the Plan Administrator.

6.05 Nondiscriminatory Exercise of Authority. Whenever any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

6.06 Indemnification of Plan Administrator. The Company agrees to indemnify and to defend to the fullest extent permitted by law any individual serving on behalf of the Plan Administrator including as a member of the Committee (including any person who formerly served on behalf of the Plan Administrator including as a member of such Committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

6.07 Limitation on Liability. Notwithstanding any of the preceding provisions of the Plan, none of the Company, any member of the Committee or any Employee or agent of any Employer, shall be liable to any Participant or any other person for any claim, loss, liability or expense incurred in connection with the Plan or the benefits provided under the Supplements.

6.08 Appointment of Benefits Administrator. The Plan Administrator shall appoint one or more Benefits Administrators to process claims for benefits. The person, persons or entity serving as Benefits Administrator shall serve at the pleasure of the Plan Administrator.

ARTICLE VII
CLAIMS PROCEDURE

7.01 Claims for Benefits Payable Under Supplements A-F.

(a) Consideration of Initial Claim.

(1) *Filing Initial Claim.* Claims for benefits under the Medical Options, the Dental Options, the Vision Options, the Long-Term Disability Option, and the Life Insurance Options (as such terms are defined in Supplements A-E) shall be made in accordance with the terms of the plan documents for such Options. An initial claim for benefits provided under Supplements A-F of the Plan shall be made to the Benefits Administrator in a manner consistent with any claims procedures established by the Plan Administrator or Benefits Administrator. With regard to Supplements A-E, the Plan shall follow the procedures applicable to Post-Service

Claims or such other procedures as may be required by law. The Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator may decide benefit claims requiring a determination of whether an individual meets the requirements for eligibility under the terms of the Plan, which determination may result in a denial, reduction, or termination of, or failure to provide payment for, a benefit. Solely with respect to claims involving a determination of an individual's eligibility under the Plan, the term "Benefits Administrator" as used in this Article shall refer also to the Plan Administrator, a member of the Company's Human Resource Department or such other designee of the Plan Administrator.

(2) *Urgent Care Claims.* In the case of an Urgent Care Claim, the Benefits Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to permit a determination whether, or to what extent, benefits are covered or payable under the Plan. If the claimant does not provide sufficient information for the Benefits Administrator to make such determination, then within 24 hours after the Benefits Administrator's receipt of the claim, the claimant shall be notified of the specific information needed to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable amount of time, but not less than 48 hours, to provide the missing information. The Benefits Administrator shall notify the claimant of its decision regarding the claim within 48 hours of the earlier of (i) the Benefits Administrator's receipt of the specified information, or (ii) the end of the period afforded the claimant to provide the specified additional information.

For purposes of this Article, an "Urgent Care Claim" is any claim under Supplement F that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or the ability of the claimant to regain maximum function, or in the opinion of the patient's doctor, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(3) *Pre-Service Claims.* In the case of a Pre-Service Claim, the Benefits Administrator shall provide notice to the claimant of its decision regarding his or her claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This 15-day period may be extended for up to 15 days due to matters beyond the control of the Plan if, prior to the expiration of the initial 15-day period, the Benefits Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Benefits Administrator expects to render a decision. If the claimant does not provide sufficient information for the Benefits Administrator to make a determination, within five days after receipt of the claim he or she shall be notified of the specific information necessary to complete the claim. Notice regarding missing information may be provided orally, unless a claimant or his or her authorized representative specifically request written notification. Once the claimant is notified, he or she shall have a reasonable

amount of time but not less than 45 days from receipt of the notice to provide the missing information.

For purposes of this Article, a "Pre-Service Claim" is any claim under Supplement F where the Plan requires approval of the benefit in advance of obtaining the medical care, in whole or in part.

(4) *Post-Service Claims.* In the case of a Post-Service Claim, the Benefits Administrator shall provide notice of an adverse determination to the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan. This 30-day period may be extended for up to 15 days for matters beyond the control of the Plan if, prior to the expiration of the initial 30-day period, the Benefits Administrator notifies the claimant of the circumstances requiring the extension and the date by which the Benefits Administrator expects to render a decision. If the claimant does not provide sufficient information for the Benefits Administrator to make a determination, the claimant shall receive notice of the specific information necessary to complete the claim. Once the claimant is notified he or she shall have a reasonable amount of time but not less than 45 days from receipt of the notice to provide the missing information.

For purposes of this Article, a "Post-Service Claim" is any claim involving a benefit under a Supplement that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

(5) *Concurrent Care Claims.* In the case of an ongoing course of treatment, the claimant shall receive notice of any reduction or early termination of treatment in advance so that the claimant may appeal the reduction or termination and obtain a determination on review before the treatment is reduced or terminated. If the claimant submits an Urgent Care Claim to extend any ongoing course of treatment beyond the period of time or number of treatments initially prescribed, the Benefits Administrator shall notify the claimant of the determination to extend the treatment within 24 hours after receipt of the claim, provided the claimant submits the claim at least 24 hours prior to the expiration of the prescribed treatment. If the request to extend any ongoing course of treatment is not an Urgent Care Claim, the Benefits Administrator will treat the claim as either a Pre-Service Claim or a Post-Service Claim (as applicable) and will consider the claim according to the timeframes applicable to Pre-Service Claims or Post-Service Claims, whichever applies. The Benefits Administrator shall be solely responsible for handling all Concurrent Care Claims.

A "Concurrent Care Claim" is any claim under Supplement F involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding a request by a claimant to extend a course of treatment beyond what has been approved.

(b) If the Benefits Administrator Denies the Initial Claim.

If the Benefits Administrator denies all or any portion of a claim, it shall provide notice of the denial stating (i) the specific reason for the denial; (ii) reference to the specific Plan provisions on which the denial is based; (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures,

including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals.

If the Benefits 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant upon request. If the Benefits 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 the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

If the Benefits Administrator denies a claimant's Urgent Care Claim in whole or in part, the Benefits Administrator shall provide a description of the expedited review process for Urgent Care Claims (as set forth below). The Benefits Administrator shall provide notice to the claimant orally, followed by written or electronic notice within three days of the oral notification.

(c) Appeal to the Benefits Administrator.

(1) *General.* If all or any portion of a claimant's health care claim is denied, the claimant has the right to appeal the decision by sending a written request for review to the Benefits Administrator within 180 days of receipt of the claim denial notification. If all or any portion of a claimant's non-health care claim is denied, the claimant has the right to appeal the decision by sending a written request for review to the Benefits Administrator within 60 days of receipt of the claim denial notification.

The claimant may submit written comments, documents, records, and other information relating to a claim for benefits. Upon request, the claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

The claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's letter shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

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

If the denial was based in whole or in part on a medical judgment, the individual or entity 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 shall be neither the individual who made the denial that is the subject of the claimant's appeal, nor the subordinate of such individual. The Benefits Administrator shall provide the claimant upon request with 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.

(2) *Expedited Review for Urgent Care Claims.* In the case of an Urgent Care Claim, a claimant may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Benefits Administrator's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or another similarly expeditious method. The Benefits Administrator shall notify the claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(3) *Pre-Service Claims.* In the case of a Pre-Service Claim, the Benefits Administrator shall provide notice to the claimant 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 the claimant's request for review.

(4) *Post-Service Claims.* In the case of a Post-Service Claim, the Benefits Administrator shall provide notice to the claimant of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

(d) If the Benefits Administrator Denies a Claim on Appeal.

If the Benefits Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (i) the specific reason or reasons for the denial; (ii) reference to the specific Plan provisions on which the denial is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures; and (v) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

If the Benefits 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 shall be provided free of charge to the claimant, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant upon request. If the Benefits 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 the medical circumstances) shall be provided free of charge to the claimant, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

(e) Appeal to the Plan Administrator of Pre- and Post-Service Claim Denials.

(1) *General.* If the Benefits Administrator denies all or any portion of a Pre-Service Claim or Post-Service Claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Benefits Administrator by sending a written request for review to the Plan Administrator within 180 days of receipt of the Benefits Administrator's notice of claim denial.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's letter shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a claim, the Plan Administrator shall conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review shall not afford any deference to the Benefits Administrator's denial of the claim on appeal.

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

(2) *Pre-Service Claims.* In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant 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 a claimant's request for review.

(3) *Post-Service Claims.* In the case of a Post-Service Claim, the Plan Administrator shall provide the claimant with notice of its determination on review within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review.

(f) If the Plan Administrator Denies a Claim on Appeal.

If the Plan Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (i) the specific reason or reasons for the denial; (ii) reference to the specific Plan provisions on which the denial is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (iv) a statement describing any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (v) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

If the Plan 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 shall be provided to the claimant free of charge, or the claimant shall be informed that such rule, guideline, protocol, or other criterion shall be provided free of charge to the claimant upon request. If the Plan 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 the claimant's medical circumstances) shall be provided to the claimant free of charge, or the claimant shall be informed that such explanation shall be provided free of charge to the claimant upon request.

In addition, the notice shall include the following statement: "A claimant and his or her plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office."

(g) Construction. This Section 7.01 shall be construed in a manner consistent with the Department of Labor claims procedures regulations.

7.02 Claims for Benefits Payable Under Supplement G.

(a) Consideration of Initial Claim.

(1) *Filing Initial Claim.* An initial claim for benefits provided under Supplement G of the Plan shall be made to the Benefits Administrator in a manner consistent with any claims procedures established by the Plan Administrator or Benefits Administrator. If an initial claim is wholly or partially denied by the Benefits Administrator, the Benefits Administrator shall, within a reasonable period of time, but no later than 90 days after receipt of the claim, notify the claimant in writing of the denial of the claim. If the claimant shall not be notified in writing of the denial of the claim within 90 days after it is received by the Benefits Administrator, the claim shall be deemed denied. A notice of denial shall be written in a manner calculated to be understood by the claimant, and shall contain: (i) the specific reason or reasons for denial of the claim; (ii) reference to the pertinent Plan provisions upon which the denial is based; (iii) a description of any additional material or information necessary for the claimant to perfect the claim, together with an explanation of why such material or information is necessary; and (iv) an explanation of the Plan's review procedure.

If special circumstances requires an extension of time for processing the initial claim, a written notice of the extension and the reason therefore shall be furnished to the claimant before the end of the initial 90-day period. In no event shall such extension exceed 90 days. If the Benefits Administrator does not respond to an initial claim within such 90 or 180-day period, as the case may be, the claim shall be deemed denied.

(b) Appeal to the Benefits Administrator of Initial Claim Denial.

If all or any portion of an initial claim for benefits is denied or is deemed to have been denied, the claimant, at the claimant's sole expense, may appeal, in writing, the denial to the Benefits Administrator within 60 days of the receipt of written notice of the denial or 60 days from the date such claim is deemed to be denied. In pursuing such appeal, the claimant or his or her duly authorized representative may review pertinent documents, and may submit issues and comments in writing. The decision on review shall be made within 60 days of receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review. If such an extension of time is required, written notice of the extension shall be furnished to the claimant before the end of the original 60 day period. The decision on review shall be made in writing, shall be written in a manner calculated to be understood by the claimant, and shall contain: (i) the specific reason or reasons for the denial; (ii) reference to the pertinent Plan provisions on which the denial is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all document, records and other information relevant to the claim for benefits; and (iv) an explanation of the Plan's claims review procedures.

If the decision on review is not furnished within such 60 or 120 day period, as the case may be, the claim shall be deemed denied on review.

(c) Appeal to the Plan Administrator.

If the Benefits Administrator denies all or any portion of a claim on appeal, or such claim is deemed denied, a claimant may file a written claim with the Plan Administrator within 60 days after the appeal has been denied in whole or in part by the Benefits Administrator, or 90 days after the claim is deemed denied, if the Benefits Administrator did not respond within the original 60 day period. Any claim with the Plan Administrator shall be processed within 60 days of its receipt by the Plan Administrator unless additional time is required to process the claim, in which event the Plan Administrator shall notify the claimant within the original 60 day period that an additional period of up to 60 days is required to process the claim. If a claim is denied in whole or in part by the Plan Administrator, written notice of the decision to deny such application may be furnished to the claimant within 60 days after receipt of the claim, or within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the claim. Each notice of claim denial shall be written in a manner calculated to be understood by the claimant and shall contain: (i) the specific reason or reasons for the denial; (ii) reference to the pertinent Plan provisions upon which the denial is based; and (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all document, records and other information relevant to the claim for benefits.

If the decision on review is not furnished within such 60 or 120 day period, as the case may be, the claim shall be deemed denied on review.

7.03 **Other Claims**. Any claim under the Plan involving Supplement H shall initially be made at the step set forth in subsection 7.01(e). Such claim shall be processed in accordance with applicable provisions of subsections 7.01(e) and 7.01(f).

7.04 **Legal Actions**. No legal action may be brought to recover from the Plan until after the claimant has exhausted all claims and appeals to the Benefits Administrator and Plan Administrator under Sections 7.01 and 7.02, as applicable. No such action may be brought after three years from the time a claim is incurred. A claim for benefits is incurred when the services giving rise to the claim were rendered.

ARTICLE VIII
PROVISIONS CONCERNING PROTECTED HEALTH INFORMATION

8.01 **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 Plan must handle Protected Health Information. "Protected Health Information" means individually identifiable health information related to a Participant or Dependent.

8.02 **Permitted Uses and Disclosure**. The Plan may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plan 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 Plan or the Privacy Standards.

8.03 **Disclosures to Company**. The Plan 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 Plan 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.

The Company, in its capacity as sponsor of the Plan, agrees to:

(a) not use or further disclose Protected Health Information received from the Plan other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;

(c) not use or disclose Protected Health Information received from the Plan for employment-related actions and decisions;

(d) not use or disclose Protected Health Information received from the Plan in connection with any other benefit or employee benefit plan of the Company (except to the extent that such other benefit, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan is a part);

(e) report to the Privacy Official, acting on behalf of the Plan, any use or disclosure of Protected Health Information received from the Plan that is inconsistent with the uses or disclosures authorized by this Section and of which the Company becomes aware;

(f) make available Protected Health Information in accordance with 45 C.F.R. § 164.524 (pertaining to an individual's access to his or her own Protected Health Information) and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(g) make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(h) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and in accordance with the Policies and Procedures Regarding Protected Health Information related to the Plan;

(i) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("HHS") or to any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with 45 C.F.R. Subchapter C, Subpart E; and

(j) if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The foregoing restrictions do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the Company or any other Employer, acting in their respective capacities as an employer.

8.04 **Adequate Separation**. There shall be adequate separation between the Plan and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only the following employees, classes of employees or other persons under the control of the Company or its affiliates may have access to Protected Health Information created under the Plan:

Privacy Official
Security Official
Members of the Benefits Department
HRIS-Benefits Analyst
Members of the Legal Department
Members of the Internal Audit Department
Members of the Committee
Any other employee of the Company or its affiliates who performs plan administration functions for the Plan and who is designated in writing by the Privacy Official or a member of the Committee as being entitled to access to Protected Health Information.

Access to and use by such individuals shall be restricted to the plan administration functions that the Company and its affiliates perform for the Plan. The Plan or the Company (or an affiliate) has 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 Plan. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plan governing their obligations under the Privacy Standards.

8.05 **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 Plan. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

8.06 **Special Amendatory Authority.** The Privacy Official appointed by the Plan Administrator pursuant to the Privacy Standards shall be authorized to make and execute any amendment to this Article that such Privacy Official deems necessary or appropriate.

ARTICLE IX
PROVISIONS CONCERNING THE SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

9.01 **General.** The Department of Health and Human Services has issued Regulations, effective April 20, 2005, that govern the manner in which a group health plan, such as the Plan, must handle Electronic Protected Health Information. "Electronic Protected Health Information" refers to Protected Health Information that is (i) maintained in Electronic Media (as defined in 45 C.F.R. Section 160.103) or (ii) transmitted by Electronic Media.

9.02 **Duty of the Plan Sponsor.** The Company shall reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted to or by the Company on behalf of the Plan. To this end, the Company shall: (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Company creates, receives, maintains or transmits on behalf of the Plan; (ii) ensure that the adequate separation required by Section 8.04 above is supported by reasonable and appropriate security measures; (iii) ensure that any agent, including a subcontractor, to whom or which the Company provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and (iv) report to the Plan any security incident involving Electronic Protected Health Information of which the Company becomes aware.

ARTICLE X
AMENDMENT OR TERMINATION OF THE PLAN

10.01 **Plan Amendment or Modification.** The Committee reserves the power at any time and from time to time to modify or amend, in whole or in part, any or all provisions of the Plan; provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he or she has become entitled under the Plan. Unless expressly provided, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan.

10.02 **Plan Termination.** The Committee reserves the right and power to discontinue or terminate the Plan at any time, without liability for such termination.

10.03 Effective Date of Amendment or Termination. Any amendment, discontinuance or termination of the Plan shall be effective as of the date the Committee determines.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.01 Information To Be Furnished. A Participant shall provide the Plan Administrator and Benefits Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.02 Right to Continued Employment. Neither the Plan nor any action taken with respect to it shall confer upon any person the right to continue in the employ of an Employer.

11.03 Plan Not Contract. The Plan shall not be deemed to be a contract between any Employer and any Employee or to be a consideration or an inducement for the employment of any Employee. No Employee shall acquire any right to be retained in an Employer's employ by virtue of the Plan, nor, upon his or her dismissal or upon his or her voluntary termination of employment, shall he or she have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, no Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

11.04 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect an Employer's rights to discipline or terminate an Employee.

11.05 Participant Responsibilities. Each Participant, Spouse and Dependent is responsible for providing the Plan Administrator and the Benefits Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Benefits Administrator shall have any obligation or duty to locate a Participant, Spouse or Dependent. If a Participant, Spouse or Dependent becomes entitled to a payment under the Plan and such payment cannot be made because (a) the current address is incorrect, (b) the Participant, Spouse or Dependent does not respond to the notice sent to the current address, (c) there are conflicting claims to such payment, or (d) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

11.06 Spendthrift Provision. No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge prior to actual receipt thereof by the payee; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge prior to such receipt shall be void; nor shall the Plan be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any person entitled to any benefit hereunder.

11.07 Written Communication. All communications in connection with the Plan made by an Employee shall become effective only when duly executed and filed with the Benefits Administrator or Plan Administrator.

11.08 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal

or equitable right against any Employer, the Plan Administrator or the Benefits Administrator, except as provided herein.

11.09 Fiduciaries. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

11.10 Severability. The provisions of the Plan are severable. If any provision of the Plan proves to be, or is finally held by any court or tribunal, board or authority of competent jurisdiction to be, illegal, unenforceable or in conflict with the Code, ERISA or any other law, that provision will be disregarded and will be void. Such invalidation will not impair the Plan or any of its other provisions.

11.11 Construction. If the Plan contains contradictory clauses or if there appears to be a conflict between its provisions, the following rules of construction will apply:

(a) The interpretation that favors the Plan as a tax-free plan will prevail over any interpretation that might render the Plan taxable.

(b) Subject to (a) above, the rules established by the Supreme Court of the State of Indiana for the construction of like instruments will apply.

11.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 11.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such court[s] in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

11.13 Funding. The Plan at all times shall be entirely unfunded and no provision shall at any time be made with respect to segregating any assets of any Employer for payment of any benefits hereunder or under the plans and programs provided under the Supplements.

11.14 No Guarantee. No Employer in any way guarantees the payment of any benefits that may be or become due to any person under the Plan. Nothing herein contained shall be deemed to give any Participant or any other person any interest in any assets of any Employer except the right to receive benefits in accordance with the provisions of the Plan.

11.15 Participant Litigation. In any action or proceeding involving the Plan, Employees or former Employees or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against an Employer or the Plan by or on behalf of any person, and such action results adversely to such person, or if a legal action arises because of conflicting benefit claims, the cost to the Employer or the Plan will be charged to the

sums, if any, that were involved in the action or were payable to the Participant, Spouse, Dependent or other person concerned. To the extent permitted by applicable law, an election to become a Participant under the Plan shall constitute a release of the Employer and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

11.16 Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

11.17 Withholding for Taxes. Notwithstanding any other provision of the Plan, an Employer or any other organization or institution providing benefits under the Plan may withhold from any payment to be made under the Plan such amount or amounts as may be required for purposes of complying with the tax withholding provisions of the Code, any state's income tax act or any applicable similar laws.

11.18 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to offset the overpaid amount against future benefits that are payable or to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization. Without limiting the generality of the foregoing, the Plan shall have the right to recover any amounts it pays in respect of a person who is not an eligible Participant or Dependent.

11.19 Costs of Administering the Plan. Except to the extent provided under a Supplement, the costs and expenses incurred in administering the Plan shall be paid by the Company.

11.20 Discrimination Rules. In the case of highly compensated Employees (as defined in Section 414(q) of the Code), benefits under the Plan shall not discriminate in favor of (a) highly compensated Employees as to eligibility to participate, or (b) highly compensated Employees as to contributions and benefits. In the case of a Key Employee (within the meaning of Section 416(i)(1) of the Code), statutory non-taxable benefits available under the Plan, for any Plan Year, provided to Key Employees, shall not exceed 25% of the aggregate of such benefits provided for all Employees under the Plan.

11.21 Extension of Plan to Related Employers.

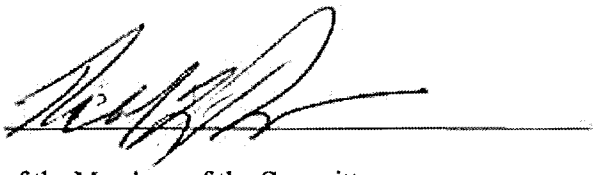
(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

IN WITNESS WHEREOF, the Committee has caused this Plan to be executed on its behalf by one of its members duly authorized, this 12th day of December. 2017. to be effective as of January 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: 

One of the Members of the Committee

SUPPLEMENT A
Participant Cost of Medical Plan Coverage Option

A-1 Purpose and Effect. The provisions of this Supplement A, in conjunction with the other provisions of the Plan, constitute the Participant Cost of Medical Plan Coverage Option under the Plan. This Supplement A sets forth the provisions governing the operation and administration of the Participant Cost of Medical Plan Coverage Option and permits a Participant to provide for the cost of coverage under the Medical Options listed in Section A-2. Applicable provisions of the Medical Options shall be considered a part of the Plan, including this Supplement, and are incorporated herein by reference.

A-2 Eligibility. A Participant may provide for the cost of coverage under the following options (collectively, the "Medical Options"), subject to the limitations noted below:

NiSource Consolidated Flex Medical Plan, as amended or restated from time to time (the "Flex Medical Plan"), if eligible to participate in such Plan:

(i) HD PPO 1 (as defined in the Flex Medical Plan), if eligible to participate in such Option.

(ii) HD PPO 2 (as defined in the Flex Medical Plan), if eligible to participate in such Option.

(iii) PPO Option (as defined in the Flex Medical Plan), if eligible to participate in such Option.

(iv) HMO Option (as defined in the Flex Medical Plan), if eligible to participate in such Option. Participation in Supplement A with regard to the cost of coverage under the HMO shall be available subject to the terms and conditions contained in the HMO certificate of coverage, the group insurance policy, and other applicable governing documents.

(v) Other Insured Arrangement Option (as defined in the Flex Medical Plan), if eligible to participate in such Option.

A-3 Amount of Medical Option Coverage. Subject to the conditions and limitations of the Plan, each Participant, pursuant to Article III of the Plan, may elect to have his or her Salary Reduction Contributions applied to the payment of the cost of coverage under a Medical Option. Such election shall be made for a Plan Year pursuant to the Participant's enrollment.

A-4 Continuation Coverage. A Qualified Beneficiary who has incurred a Qualifying Event shall have the right to elect continuation coverage under this Supplement A, but only to the extent that such election of continuation coverage is consistent with (i) Sections 125, (ii) if applicable, 4980B of the Code (and any regulations, rulings, releases or statements issued thereunder), and (iii) the terms of the applicable Medical Option. The terms and conditions of Section 4980B of the Code and of the applicable Medical Option, including the period of such continuation coverage, are incorporated herein by reference.

A-5 Continuation Coverage During Military Leave. An Eligible Employee shall have the right to elect continuation coverage under this Supplement A to the extent that he or she is entitled to continuation coverage under USERRA.

A-6 Continuation Coverage and Severance Pay. An Employee or former Employee may apply any severance pay as a Salary Reduction Contribution to the payment of the cost of continuing coverage under a Medical Option to the extent consistent with the applicable Medical Option and law.

A-7 Use of Terms. If any term of this Supplement A and the remainder of the Plan conflicts, the term contained within this Supplement A shall govern.

SUPPLEMENT B
Participant Cost of Dental Plan Coverage Option

B-1 Purpose and Effect. The provisions of this Supplement B, in conjunction with the other provisions of the Plan, constitute the Participant Cost of Dental Plan Coverage Option under the Plan. This Supplement B sets forth the provisions governing the operation and administration of such Option and permits a Participant to provide for the cost of coverage under the Dental Options listed in Section B-2. Applicable provisions of the Dental Options shall be considered a part of the Plan, including this Supplement, and are incorporated herein by reference

B-2 Eligibility. A Participant may provide for the cost of coverage under the following options (collectively, the "Dental Options"), subject to the limitations noted:

NiSource Dental Plan, if eligible to participate in such Plan:

(i) Preventive Dental Option (as defined in the NiSource Dental Plan), if eligible to participate in such Option.

(ii) Dental Plan Option (as defined in the NiSource Dental Plan), if eligible to participate in such Option.

(iii) Dental Plus Option (as defined in the NiSource Dental Plan), if eligible to participate in such Option.

B-3 Amount of Dental Option Coverage. Subject to the conditions and limitations of the Plan, each Participant, pursuant to Article III of the Plan, may elect to have his or her Salary Reduction Contributions applied to the payment of the cost of coverage under a Dental Option. Such election shall be made for a Plan Year pursuant to the Participant's enrollment.

B-4 Continuation Coverage. A Qualified Beneficiary who has incurred a Qualifying Event shall have the right to elect continuation coverage under this Supplement B, but only to the extent that such election of continuation coverage is consistent with (i) Sections 125, (ii) if applicable, 4980B of the Code (and any regulations, rulings, releases or statements issued thereunder), and (iii) the terms of the applicable Dental Option. The terms and conditions of Section 4980B of the Code and of the applicable Dental Option, including the period of such continuation coverage, are incorporated herein by reference.

B-5 Continuation Coverage During Military Leave. An Eligible Employee shall have the right to elect continuation coverage under this Supplement B to the extent that he or she is entitled to continuation coverage under USERRA.

B-6 Continuation Coverage and Severance Pay. An Employee or former Employee may apply any severance pay as a Salary Reduction Contribution to the payment of the cost of continuing coverage under a Dental Option to the extent consistent with the applicable Dental Option and law.

B-7 Use of Terms. If any term of this Supplement B and the remainder of the Plan conflicts, the term contained within this Supplement B shall govern.

SUPPLEMENT C
Participant Cost of Vision Plan Coverage Option

C-1 Purpose and Effect. The provisions of this Supplement C, in conjunction with the other provisions of the Plan, constitute the Participant Cost of Vision Plan Coverage Option under the Plan. This Supplement C sets forth the provisions governing the operation and administration of such Option and permits a Participant to provide for the cost of coverage under the Vision Options listed in Section C-2. Applicable provisions of the Vision Options shall be considered a part of the Plan, including this Supplement, and are incorporated herein by reference.

C-2 Eligibility. A Participant may provide for the cost of coverage under the following options (collectively, the "Vision Options"), subject to the limitations noted:

(a) NiSource Vision Plan, if eligible to participate in such Plan:

(i) Basic Vision Option, if eligible to participate in such Option.

(ii) Vision Plan Option, if eligible to participate in such Option.

(b) NiSource Inc. Bargaining Unit Employees Vision Plan, if eligible to participate in such Plan.

C-3 Amount of Vision Option Coverage. Subject to the conditions and limitations of the Plan, each Participant, pursuant to Article III of the Plan, may elect to have his or her Salary Reduction Contributions applied to the payment of the cost of coverage under a Vision Option. Such election shall be made for a Plan Year pursuant to the Participant's enrollment.

C-4 Continuation Coverage. A Qualified Beneficiary who has incurred a Qualifying Event shall have the right to elect continuation coverage under this Supplement C, but only to the extent that such election of continuation coverage is consistent with (i) Sections 125, (ii) if applicable, 4980B of the Code (and any regulations, rulings, releases or statements issued thereunder), and (iii) the terms of the applicable Vision Option. The terms and conditions of Section 4980B of the Code and of the applicable Vision Option, including the period of such continuation coverage, are incorporated herein by reference.

C-5 Continuation Coverage During Military Leave. An Eligible Employee shall have the right to elect continuation coverage under this Supplement C to the extent that he or she is entitled to continuation coverage under USERRA.

C-6 Continuation Coverage and Severance Pay. An Employee or former Employee may apply any severance pay as a Salary Reduction Contribution to the payment of the cost of continuing coverage under a Vision Option to the extent consistent with the Vision Options and law.

C-7 Use of Terms. If any term of this Supplement C and the remainder of the Plan conflicts, the term contained within this Supplement C shall govern.

SUPPLEMENT D
Participant Cost of Long-Term Disability Plan Coverage Option

D-1 Purpose and Effect. The provisions of this Supplement D, in conjunction with the other provisions of the Plan, constitute the Participant Cost of Long-Term Disability Plan Coverage Option under the Plan. This Supplement D sets forth the provisions governing the operation and administration of such Option and permits a Participant to provide for the cost of coverage under the Long-Term Disability Option listed in Section D-2. Applicable provisions of the Long-Term Disability Option shall be considered a part of the Plan, including this Supplement, and are incorporated herein by reference.

D-2 Eligibility. A Participant may provide for the cost of the available levels of coverage under the following option (the "Long-Term Disability Option"):

NiSource Long-Term Disability Plan, if eligible to participate in such Plan.

A Full-Time Employee may participate in this Supplement D. No Part-Time Employee may participate in this Supplement D.

D-3 Amount of Long-Term Disability Option Coverage. Subject to the conditions and limitations of the Plan, each Participant, pursuant to Article III of the Plan, may elect to have his or her Salary Reduction Contributions applied to the payment of the cost of coverage under the Long-Term Disability Option. Such election shall be made for a Plan Year pursuant to the Participant's enrollment.

D-4 Continuation Coverage and Severance Pay. An Employee or former Employee may apply any severance pay as a Salary Reduction Contribution to the payment of the cost of continuing coverage under the Long-Term Disability Option to the extent consistent with the Long-Term Disability Option and law.

D-5 Use of Terms. If any term of this Supplement D and the remainder of the Plan conflicts, the term contained within this Supplement D shall govern.

SUPPLEMENT E
Participant Cost of Life Insurance Coverage Option

E-1 Purpose and Effect. The provisions of this Supplement E, in conjunction with the other provisions of the Plan, constitute the Participant Cost of Life Insurance Coverage Option under the Plan. This Supplement E sets forth the provisions governing the operation and administration of such Option and permits a Participant to provide for the cost of various levels of coverage under the Life Insurance Options listed in Section E-2. Applicable provisions of the Life Insurance Options shall be considered a part of the Plan, including this Supplement, and are incorporated herein by reference.

E-2 Eligibility. A Participant may provide for the cost of the available levels of coverage under the following options (collectively, the "Life Insurance Options"):

(a) NiSource Life Insurance Plan, if eligible to participate in such Plan.

(b) Northern Indiana Public Service Company Employee Life Insurance Plan, if eligible to participate in such Plan.

E-3 Amount of Life Insurance Options Coverage. Subject to the conditions and limitations of the Plan, each Participant, pursuant to Article III of the Plan, may elect to have his or her Salary Reduction Contributions applied to the payment of the cost of coverage under the Life Insurance Options. Such election shall be made for a Plan Year pursuant to the Participant's enrollment. Notwithstanding the foregoing, Salary Reduction Contributions may not be applied under the Plan to the payment of the cost of life insurance coverage upon the lives of Dependents. Payment of the cost of life insurance coverage upon the lives of Dependents may be made outside the Plan on an after-tax basis.

E-4 Continuation Coverage and Severance Pay. An Employee or former Employee may apply any severance pay as a Salary Reduction Contribution to the payment of the cost of continuing coverage under the Life Insurance Options to the extent consistent with the Life Insurance Options and law.

E-5 Use of Terms. If any term of this Supplement E and the remainder of the Plan conflicts, the term contained within this Supplement E shall govern.

SUPPLEMENT F
Medical Expense Reimbursement Option

F-1 Purpose and Effect. The provisions of this Supplement F, in conjunction with the other provisions of the Plan, constitute the Medical Expense Reimbursement Option under the Plan, which Option is intended to constitute a medical reimbursement plan under Section 105(h) of the Code. This Supplement F sets forth the provisions governing the operation and administration of such Option, specifies the amount of Salary Reduction Contributions a Participant may allocate to his or her Medical Expense Reimbursement Account established under the Medical Expense Reimbursement Option, and describes the Medical Expenses that may be reimbursed from his or her Medical Expense Reimbursement Account.

F-2 Eligibility. No Employee may participate in Supplements F and H at the same time. In addition, no Employee who is receiving benefits under the Long-Term Disability Option may participate in Supplement F.

F-3 Medical Expense Reimbursement Account. Subject to the conditions and limitations of the remainder of the Plan and this Supplement F, a Medical Expense Reimbursement Account shall be established and maintained for a Participant under this Supplement F for a Plan Year if the Participant elects by filing an enrollment under Article III to have a portion of his or her Salary Reduction Contributions allocated to such Account. The amount of Salary Reduction Contributions of a Participant that may be allocated to his or her Medical Expense Reimbursement Account for any Plan Year shall not exceed the Medical Expense Reimbursement Maximum Amount, and shall not be less than $60. As used in this Supplement F, "Medical Expense Reimbursement Maximum Amount" means the maximum amount permitted by Code Section 125(i), subject to any additional limitation imposed by the Plan Administrator. Notwithstanding the foregoing, the Plan Administrator may limit or suspend the allocations to a Medical Expense Reimbursement Account of a highly-compensated Employee (within the meaning of Section 414(q) of the Code) to the extent deemed necessary to satisfy any nondiscrimination requirements of the Code. A Participant shall be entitled to reimbursement from his or her Medical Expense Reimbursement Account for the Medical Expenses (as defined in Section F-4 below) incurred during the Plan Year to the extent that such Medical Expenses for such Plan Year do not exceed the amount to be allocated to the Participant's Medical Expense Reimbursement Account for such Plan Year pursuant to Article III. During the Plan Year the Participant may be reimbursed for Medical Expenses up to the full dollar amount to be allocated to the Participant's Medical Expense Reimbursement Account for such Plan Year, less any prior reimbursements for that Plan Year. The maximum amount of reimbursement under this Supplement F shall be available at all times during the Plan Year (reduced as provided in the immediately preceding sentence). Accordingly, such maximum amount shall not at any particular time during the Plan Year relate to the extent to which Salary Reduction Contributions have actually been allocated to the Participant's Medical Expense Reimbursement Account. Medical Expenses will be deemed to have been incurred in the Plan Year in which the applicable health care is provided and not the Plan Year in which the Participant is billed, charged for or actually pays for such care.

Notwithstanding the foregoing, no Medical Expenses shall be reimbursed for a CPG Spin-Off Employee on or after the Separation Date.

F-4 Medical Expenses. "Medical Expenses," means amounts paid by a Participant for Medical Care of himself or herself, a Spouse or any Dependent, to the extent such payment is not reimbursed

from any other source, and to the extent such amounts are not taken as a deduction on the Participant's income tax return. If there is a policy, plan or any other arrangement in effect providing for payment of such Medical Care in whole or in part, then to the extent of the coverage under such other policy or plan, reimbursement shall not be made out of the Medical Expense Reimbursement Account of the Participant. "Medical Care" shall have the meaning set forth in Section 213(d) of the Code, including any regulations, rulings, statements and releases issued thereunder.

F-5 Examples of Covered Medical Expenses. Covered Medical Expenses include, but are not limited to the following:

(a) Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.

(b) Prescription vision expenses (including eyeglasses, contact lenses, and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).

(c) Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):

- Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
- Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;
- Services for chromosome or fertility studies;
- Treatment (other than surgery, which is covered by the medical plan) of corns, bunions, calluses, foot structural disorders, etc.;
- Services related to sexual dysfunctions or inadequacies;
- Ace bandages, support hose, or other pressure garments prescribed by a physician;
- Charges for medical expenses in excess of reasonable and customary expenses;
- Acupuncture for pain relief as performed by a licensed practitioner;
- Prescribed drugs and medicines (and insulin) used for medical care (as that term is defined in Section 213(d)(1) of the Code);
- Orthodontic services not covered by a health care plan;
- Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate of 10¢ per mile (plus tolls and parking) may be used;

- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;
- Hypnosis for treatment of an illness;
- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;
- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;
- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;
- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;
- Special car controls for the handicapped; and
- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victims may qualify for reimbursement).

F-6 Examples of Non-Reimbursable Medical Expenses. Examples of non-reimbursable expenses include, but are not limited to, the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;
- Health club dues, YMCA dues, steam bath, etc.;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc.;

- Cosmetics, toiletries, toothpaste, etc.;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Expenses for medicines or drugs (other than insulin), unless such medicines or drugs are prescribed drugs (determined without regard to whether such medicines or drugs are available without a prescription); provided, however, that prior to January 16, 2011, expenses may be incurred through use of a Medical Expense Reimbursement Account debit card for medicines or drugs that are not prescribed drugs, if use of such debit card complies with guidance set forth, or identified, in Internal Revenue Service Notice 2010-59; provided, further, that on and after January 16, 2011, the Medical Expense Reimbursement Account debit card may not be used for medicines or drugs available without a prescription, even if such medicines or drugs are prescribed.
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving an Employee's car;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;
- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

F-7 Manner of Making Payments. Subject to Section F-3, at such time and in such manner during a Plan Year as the Plan Administrator may prescribe, the Plan shall reimburse each Participant from his or her Medical Expense Reimbursement Account for Medical Expenses incurred during such Plan Year or the Grace Period. The Participant must furnish to the Benefits Administrator satisfactory evidence that such Medical Expenses have been incurred and paid by a Participant, Spouse or Dependent and have not been previously reimbursed or are not reimbursable from any other source.

Each Participant will be issued a debit card for use for reimbursement of Medical Expenses. The debit card may be used only for eligible Medical Expenses, up to the full dollar amount to be allocated to the Participant's Medical Expense Reimbursement Account for the Plan Year, less any prior reimbursements for the Plan Year. By using the debit card, the Participant shall certify that he or she has not been reimbursed for the Medical Expense and will not seek reimbursement under any other plan.

A claim made through a debit card may be automatically substantiated if: (1) the dollar amount of the transaction is equal to the co-payment under the Participant's Medical Option (as defined in Supplement A); (2) the claim is for a recurring expense that matches previous expenses as to amount, provider and time period; or (3) the merchant, service provider, or independent third-party provider, at the time and point of sale, provides information to verify that the charge is for a Medical Expense. If the debit card claim cannot be automatically substantiated as described

above, the Participant must acquire and retain documentation (such as receipts) to substantiate the claim. The Plan Administrator and Benefits Administrator reserve the right to request such documentation and a claim form from the Participant to substantiate claims made via debit card. If the Participant receives payment for excess or ineligible Medical Expenses through the debit card, the Plan Administrator and Benefits Administrator reserve the right to recoup the mistaken payment. Such recoupment shall be made pursuant to the procedures set forth in Revenue Ruling 2003-43, 2003-21 I.R.B. 935, or any successor ruling or regulation issued by the Internal Revenue Service.

Alternatively, a Participant may seek reimbursement for Medical Expenses by filing a claim form. Claim forms will be provided by the Plan Administrator or the Benefits Administrator and must include, with respect to eligible Medical Expenses covered by a Medical Option or any other plan or insurance policy, a copy of the explanation of benefits form relating to such Medical Expenses that indicates the amount not paid by such plan or plans and, with respect to any other Medical Expenses, copies of itemized receipts obtained from the provider of the covered expense. Reimbursement payments shall be made directly to the Participant as soon as practicable after approval thereof.

Medical Expenses incurred in a Plan Year or the Grace Period not properly reported to the Benefits Administrator by June 15 following the end of a Plan Year shall not be reimbursed under this Supplement F. Any amounts remaining in a Participant's Medical Expense Reimbursement Account at the end of a Plan Year and the Grace Period and after all Medical Expenses have been timely reported, substantiated and reimbursed shall be forfeited. Any forfeited amounts shall be used to reduce administrative expenses of the Plan for subsequent Plan Years.

F-8 Grace Period. Notwithstanding any provision of the Plan to the contrary, if the Participant does not incur sufficient expenses during the Plan Year to deplete the Salary Reduction Contributions in his or her Medical Expense Reimbursement Account, the Plan shall reimburse the Participant for Medical Expenses incurred during the Grace Period. Unused Salary Reduction Contributions may be used during the Grace Period only to pay or reimburse Medical Expenses and not to pay or reimburse any other expense. The Participant must submit claims for expenses incurred during the Grace Period in the manner described in Section F-7. If, after deducting Medical Expenses incurred during the Grace Period, the Participant has not depleted the Salary Reduction Contributions in his or her Medical Expense Reimbursement Account, any amounts remaining in the Participant's Medical Expense Reimbursement Account shall not be carried forward to any subsequent period or be cashed out, but shall be forfeited and shall be used to reduce administrative expenses of the Plan in subsequent Plan Years.

F-9 Use of Terms. If any term of this Supplement F and the remainder of the Plan conflicts, the term contained within this Supplement F shall govern.

F-10 Continuation Coverage. A Qualified Beneficiary who has incurred a Qualifying Event shall have the right to elect COBRA continuation coverage under this Supplement F, but only to the extent that such election of continuation coverage is consistent with Sections 125 and 4980B of the Code (and any regulations, rulings, releases or statements issued thereunder). The maximum COBRA continuation coverage period shall extend from the date of the Qualifying Event until the last day of the Plan Year in which the Qualifying Event occurs and the Grace Period following such Plan Year. As a condition of obtaining COBRA continuation coverage, the Employee or former Employee must make after-tax contributions to the Plan in the amount required by the Plan Administrator. The amount of such after-tax contributions shall not exceed the maximum

amount allowed under Section 4980B of the Code (and any regulations, rulings, releases or statements issued thereunder).

F-11 Nature of COBRA Continuation Coverage. An Employee, former Employee or other Qualified Beneficiary who has incurred a Qualifying Event and who has elected COBRA continuation coverage under this Supplement F shall be entitled to reimbursement from the Employee's or former Employee's Medical Expense Reimbursement Account for Medical Expenses to the extent of (i) the amount allocated to the Participant's Medical Expense Reimbursement Account for the Plan Year pursuant to Article III, less (ii) the amount reimbursed to the Participant during such Plan Year prior to the Qualifying Event.

Notwithstanding the foregoing, no Medical Expenses shall be reimbursed on or after the Separation Date for a person (A) who (i) is a former employee of the Company or of a Related Employer, of a CPG Related Employer, or of a Columbia Divested Company and whose last employment with any of such parties prior to termination was with a CPG Related Employer or a Columbia Divested Company (a "CPG Participant"), or (ii) is or was a dependent of a CPG Participant or of an employee of CPG or of a CPG Related Employer; and (B) whose coverage under the Plan ended prior to the Separation Date because of a Qualifying Event.

F-12 Continuation Coverage During Military Leave. An Eligible Employee shall have the right to elect continuation coverage under this Supplement F to the extent that he or she is entitled to continuation coverage under USERRA.

F-13 Coverage While Receiving, or Appealing Denial of, Short-Term Disability Benefits. Eligibility for coverage under this Supplement F shall continue for an Eligible Employee if the Employee is receiving benefits under an Employer's short-term disability plan or if an appeal for such benefits is pending or if the period during which such an appeal could be made has not expired. All required contributions must continue to be made in order to remain eligible for such coverage.

SUPPLEMENT G
Dependent Care Expense Option

G-1 Purpose and Effect. The provisions of this Supplement G, in conjunction with the other provisions of the Plan, constitute the Dependent Care Expense Option under the Plan, which Option is intended to constitute a "dependent care assistance program" under Section 129 of the Code. This Supplement G sets forth the provisions governing the operation and administration of such Option, specifies the amount of Salary Reduction Contributions a Participant may allocate to his or her Dependent Care Expense Account established under the Dependent Care Expense Option, and describes the Dependent Care Expenses that may be reimbursed from his or her Dependent Care Expense Account.

G-2 Eligibility. No Employee who is receiving benefits under the Long-Term Disability Option may participate in Supplement G.

G-3 Dependent Care Expense Account. Subject to the conditions and limitations of the remainder of the Plan and this Supplement G, a Dependent Care Expense Account shall be established and maintained for a Participant under this Supplement G for a Plan Year if the Participant elects by filing an enrollment under Article III to have a portion of his or her Salary Reduction Contributions allocated to such Account. The amount of Salary Reduction Contributions of a Participant that may be allocated to a Participant's Dependent Care Expense Account for any Plan Year shall not exceed $5,000 ($2,500 if a separate federal income tax return is filed by a married Participant) and shall not be less than $60. Notwithstanding the foregoing, the Plan Administrator may limit or suspend the allocations to a Dependent Care Expense Account of a highly-compensated Employee (within the meaning of Section 414(q) of the Code) to the extent deemed necessary to satisfy any nondiscrimination requirements of the Code. A Participant shall be entitled to reimbursement from his or her Dependent Care Expense Account for the Dependent Care Expenses (as defined in Section G-4) incurred during that Plan Year with respect to the Participant's Dependent Members (as defined in Section G-5), to the extent that such Dependent Care Expenses do not exceed an amount equal to the smallest of:

(a) The total Dependent Care Expenses incurred during that Plan Year;

(b) In the case of a Participant who is not married at the close of the Plan Year, one-half of the Earned Income of such Participant for such Plan Year;

(c) In the case of a Participant who is married at the close of the Plan Year, (i) the lesser of one-half of the Earned Income of the Participant, or (ii) one-half of the Earned Income of the Participant's Spouse for such Plan Year; or

(d) The amount allocated by the Participant to his or her Dependent Care Expense Account for such Plan Year.

If a Participant's Spouse is also covered by a dependent care assistance program, such Spouse's salary reduction contributions to such program shall reduce the $5,000 limit on allocations provided above. Dependent Care Expenses will be deemed to have been incurred in the Plan Year in which the dependent care is provided and not when the Participant is billed, charged for or actually pays for such care. For purposes of this Supplement G, "Earned Income" for a Plan Year means a person's wages, salaries, tips and other employee compensation, plus the amount of

any net earnings from self employment, for the Plan Year, as defined in Section 32(c)(2) of the Code, but shall not include amounts paid or incurred by an Employer for dependent care assistance to the person. In determining the Earned Income of a Spouse who is a student or incapable of caring for himself or herself, the provisions of Section 21(d)(2) of the Code shall apply, and such Spouse shall be deemed to be gainfully employed and to have Earned Income of $250 per month if the Participant has only one Dependent Member, and $500 per month if the Participant has two or more Dependent Members. In the case of any husband and wife, the preceding sentence shall apply to only one spouse for any one month.

Notwithstanding the foregoing, no Dependent Care Expenses shall be reimbursed for a CPG Spin-Off Employee with respect to such Employee's Dependent Members on or after the Separation Date.

G-4 Dependent Care Expenses. The term "Dependent Care Expenses" means (subject to the limits set forth in Section G-6 below) amounts paid by a Participant during a Plan Year for the following employment-related expenses incurred to enable the Participant or the Participant's Spouse to be gainfully employed during such Plan Year:

(a) All expenses for ordinary and usual household services necessary for the care of a Dependent Member (as defined in Section G-5), including, but not limited to, domestic care for such Dependent Member and services of a housekeeper, maid, cook, nurse or other person whose duties, in whole or in part, are to provide for the care of such Dependent Member; and

(b) All other expenses for the care of a Dependent Member including, but not limited to, Dependent Care Center expenses and private home expenses.

G-5 Dependent Member. A "Dependent Member" shall mean: (a) any Dependent of the Participant under 13 years of age who is a "qualifying child" (as defined in Section 152(a)(1) of the Code) of the Participant; (b) any Dependent of the Participant who is physically or mentally incapable of caring for himself or herself; or (c) a Participant's Spouse who is physically or mentally incapable of caring for himself or herself. In addition to the foregoing, in order to be considered a Dependent Member, a person described in (b) or (c) must have the same principal place of abode as the Participant for more than half of the year and, if services are provided outside the home, must regularly spend at least 8 hours each day in the Participant's household.

G-6 Limitation on Dependent Care Expenses. In no event shall a Participant be reimbursed for any of the following expenses under the Dependent Care Expense Option:

(a) Any employment-related expenses incurred for services outside the Participant's household (including expenses for services rendered by a Dependent Care Center), unless such expenses are incurred for the care of either (i) a Dependent under 13 years of age who is a "qualifying child" (as defined in Section 152(a)(1) of the Code) of the Participant, or (ii) any other Dependent who regularly spends at least 8 hours per day in the Participant's household;

(b) Any employment-related expenses incurred for services outside the Participant's household by a Dependent Care Center, unless such Center (i) complies with all applicable state and local laws and regulations, (ii) provides care for more than six individuals (other than those residing at the Center) and (iii) receives a fee, payment or

grant for providing services for such individuals (regardless of whether the Center is operated for profit);

(c) Any expenses that are not incurred by a Participant to enable the Participant to be gainfully employed by an Employer, such as expenses of a housekeeper, maid, cook, nurse or other person whose duties are not, in whole or in part, to provide care for a Dependent;

(d) Educational expenses of a Dependent;

(e) Expenses paid for food and clothing;

(f) Expenses paid by a Participant to an individual who is a member of the Participant's Family, unless (i) an exemption is not claimed with respect to such Family member by such Participant or the Participant's Spouse under Section 151(c) of the Code, and (ii) such Family member has attained the age of 19 years at the close of the taxable year of such Participant in which such expenses arise;

(g) Expenses for health care;

(h) Expenses for services outside the Participant's household at a camp where the Dependent stays overnight;

(i) If the Dependent is a child, expenses not incurred for the physical care of such child; and

(j) Any other expenses that would not be considered employment-related expenses under Section 21(b) of the Code.

G-7 Examples of Eligible Dependent Care Expenses. If the requirements of this Supplement G are met, eligible Dependent care expenses include the charges of:

- Dependent Care Centers;
- Family day care providers;
- Babysitters;
- Nursery schools;
- Caregivers for a disabled Dependent or Spouse who resides in the Participant's household; and
- Household services, provided that a portion of such expenses are for a Dependent Member incurred to insure such Dependent's well being and maintenance.

G-8 Manner of Making Payments. Subject to Section G-3, at such time and in such manner during a Plan Year as the Plan Administrator may prescribe (but not more frequently than weekly), the Plan shall reimburse each Participant from his or her Dependent Care Expense Account for Dependent Care Expenses incurred during such Plan Year, provided that the Plan Participant furnishes to the Benefits Administrator satisfactory evidence that such Dependent Care Expenses have been incurred and paid by the Participant or any other member of his or her Family and have not been previously reimbursed or are not reimbursable from any other source. Amounts that cannot be reimbursed because a Participant's Dependent Care Expense Account contains

insufficient funds will be reimbursed at the end of the next following bi-weekly period in which such Account contains sufficient funds. Claims for Dependent Care Expenses must be submitted on claim forms provided by the Plan Administrator or the Benefits Administrator and must include itemized bills (if available), or a signed statement from the Day Care Center or provider, certifying the amount, time and nature of the services provided. The claim form will not be considered properly filed unless it contains complete information as to the following items:

(a) Name, address and taxpayer identification number of the individual or institution to which payment was made. (No taxpayer identification number is necessary if the institution to which payment was made is an organization described in Section 501(c)(3) of the Code and exempt from tax under Section 501(a) of the Code);

(b) The time period for which payment was made;

(c) The amount of the payment; and

(d) The names and dates of birth of the Dependent Members who received the care.

Reimbursement payments shall be made directly to the Participant by whom such Dependent Care Expenses have been incurred as soon as practicable after approval thereof. Dependent Care Expenses not properly reported to the Benefits Administrator by June 15 following the last day of a Plan Year shall not be reimbursed under this Supplement G. A pending claim that remains unpaid at the end of a Plan Year may not be resubmitted in the following Plan Year. Any amounts remaining in a Participant's Dependent Care Expense Account at the end of a Plan Year shall be forfeited to the extent the Participant has no reimbursable Dependent Care Expenses for that Plan Year, and shall be used to reduce administrative expenses of the Plan for subsequent Plan Years.

G-9 Coverage While Receiving, or Appealing Denial of, Short-Term Disability Benefits. Eligibility for coverage under this Supplement G shall continue for an Eligible Employee if the Employee is receiving benefits under an Employer's short-term disability plan or if an appeal for such benefits is pending or if the period during which such an appeal could be made has not expired. All required contributions must continue to be made in order to remain eligible for such coverage.

G-10 Nondiscrimination Requirements. The provisions set forth below shall apply with respect to this Supplement G.

(a) The contributions or benefits provided under the Dependent Care Expense Option shall not discriminate in favor of Employees who are highly compensated Employees (within the meaning of Section 414(q) of the Code) or their Dependents.

(b) The Dependent Care Expense Option shall benefit Employees who qualify under a classification set up by the Plan Administrator and found by the Secretary of the Treasury not to be discriminatory in favor of Employees who are highly compensated Employees (within the meaning of Section 414(q) of the Code) or their Dependents.

(c) Not more than 25% of the amounts paid or incurred by the Plan for reimbursement under the Dependent Care Expense Option during a Plan Year may be provided for a class of individuals who are shareholders or part owners of the Company or an affiliate (or their Spouses or Dependents), each of whom (on any day during the Plan Year) owns more than 5% of the capital stock or the capital or profits interest in an Employer.

(d) The average benefits provided under all dependent care assistance programs and plans of the Company or an affiliate during any Plan Year to Employees who are not highly compensated Employees (within the meaning of Section 414(q) of the Code) shall be at least 55% of the average benefits provided to highly compensated Employees under all such programs and plans of the Company or an affiliate. For purposes of this Section, in the case of any dependent care assistance provided through a salary reduction agreement, Employees whose compensation is less than $25,000 may be disregarded. The term "compensation" shall have the meaning set forth in Section 414(q)(4) of the Code, or may be determined on any other basis that does not discriminate in favor of highly compensated Employees under rules prescribed by the Secretary of the Treasury.

G-11 Nonduplication of Benefits. A Participant shall not be reimbursed for Dependent Care Expenses under this Supplement G to the extent that such Expenses are paid to or for the benefit of the Participant, or to or for the benefit of any member of his or her Family, under the provisions of any other plan or program.

G-12 Use of Terms. If any term of this Supplement G and the remainder of the Plan conflicts, the term contained within this Supplement G shall govern.

SUPPLEMENT H
Health Savings Account Option

H-1 Purpose and Effect. The provisions of this Supplement H, in conjunction with the other provisions of the Plan, constitute the Health Savings Account Option under the Plan. This Supplement H specifies the amount of Salary Reduction Contributions a Participant may allocate to his or her Health Savings Account.

H-2 Eligibility. An Employee may participate in Supplement H only if he or she is covered by the HD PPO 1 or HD PPO 2 medical plan offered by the Company; is not covered by any other health plan that is not an HDHP; is not enrolled in Medicare Part A or Part B; and may not be claimed as a dependent on another person's Federal tax return.

No Employee may participate in Supplements F and H at the same time. An Employee will not be deemed to be participating in Supplement F during a Plan Year's Grace Period if the balance of such Employee's Medical Expense Reimbursement Account, determined on a cash basis (the "Medical Expense Reimbursement Account Balance"), has been reduced to zero as of the end of such Plan Year. A Participant in Supplement F during a Plan Year who has a positive Medical Expense Reimbursement Account Balance as of the end of such Plan Year may not participate in this Supplement H until the first day of the month following the expiration of the such Plan Year's Grace Period. In such event, the total annual contribution to such Participant's Health Savings Account under this Supplement H shall be prorated according to the number of months for which such Participant is eligible to participate in this Supplement H.

H-3 Health Savings Account Contributions. Subject to the conditions and limitations of the Plan and this Supplement H, a Participant, by filing an enrollment under Article III, may elect to have a portion of his or her Salary Reduction Contributions allocated to a Health Savings Account. The following terms and conditions shall apply:

(a) If a Participant has Employee-only coverage under HD PPO 1 or HD PPO 2, the Participant may allocate up to the Code limit for Employee-Only coverage, prorated according to the number of months the Participant is eligible to participate in this Supplement H.

(b) If a Participant has family coverage under HD PPO 1 or HD PPO 2, the Participant may allocate up to the Code limit for family coverage, prorated according to the number of months the Participant is eligible to participate in this Supplement H.

(c) If a Participant has coverage under more than one HDHP, the maximum contribution under Supplement H shall be limited as prescribed by law.

(d) An Employer shall automatically make an annual contribution (in an amount to be determined by the Company) on the Participant's behalf to the Health Savings Account of any Participant who is covered under HD PPO 1 or HD PPO 2 as of the first day of a Plan Year, provided that such Participant is eligible to participate in this Supplement H and provided further that the Participant has, on or before the first day of such Plan Year, established or activated a Health Savings Account in the manner provided by the Plan. Notwithstanding the foregoing, no such contribution shall be made to the Health Savings Account of any Participant if such Participant is receiving benefits under the Long-Term

Disability Option (as defined in Supplement D) or is otherwise on an unpaid leave of absence. In addition, for the avoidance of doubt, except as specifically provided in the Flex Medical Plan with respect to a one-time contribution on behalf of certain former NIPSCO Represented Employees who retire on or after January 1, 2015 and before January 1, 2020, and who satisfy the criteria set forth in the Flex Medical Plan related to such contribution, no Employer contribution shall be made to the Health Savings Account of any "Retiree," as that term is defined in the Flex Medical Plan (as defined in Supplement A). If, after the first day of the Plan Year, a Participant who has not previously received an annual HSA contribution from an Employer for the Plan Year becomes newly eligible to participate in this Supplement H, establishes or activates a Health Savings Account in the manner provided by the Plan in order to receive such contribution, or returns to employment with an Employer in an active status after having received benefits under the Long-Term Disability Option or after having completed an unpaid leave of absence (any of the foregoing, a "triggering event"), an Employer shall make a contribution on the Participant's behalf to the Participant's Health Savings Account for such Plan Year, in an amount to be determined by the Company that is pro-rated according to the number of full months remaining in the Plan Year after the occurrence of the triggering event giving rise to the Employer contribution, provided that such Participant is eligible to participate in this Supplement H and provided further that the Participant has established or activated a Health Savings Account in the manner provided by the Plan. Any Employer contribution referred to in this paragraph shall be further subject to any limitations imposed by the Code or the regulations thereunder.

H-4 Use of Terms. If any term of this Supplement H and the remainder of the Plan conflicts, the term contained within this Supplement H shall govern.

NISOURCE
LONG-TERM DISABILITY PLAN

As Amended and Restated
Effective as of the Separation Date (defined herein)

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Plan 1

ARTICLE II DEFINITIONS 1
2.01 Annual Enrollment Period 1
2.02 Applicable Group Insurance Certificate 1
2.03 Applicable SPD 1
2.04 Code 1
2.05 Committee 1
2.06 Company 1
2.07 CPG 1
2.08 CPG Related Employer 1
2.09 CPG Spin-Off 2
2.10 CPG Spin-Off Employee 2
2.11 Employee 2
2.12 Employer 2
2.13 ERISA 2
2.14 FMLA 2
2.15 Insurer 2
2.16 Participant 2
2.17 Plan 3
2.18 Plan Administrator 3
2.19 Plan Year 3
2.20 Related Employer 3
2.21 Represented 3
2.22 Separation Date 3
2.23 Status Change 3
2.24 Construction 3

ARTICLE III PARTICIPATION 3
3.01 Eligibility 3
3.02 Enrollment 3

ARTICLE IV CONTRIBUTIONS TO THE PLAN 4
4.01 Participant Contributions 4
4.02 Employer Contributions 4

ARTICLE V PLAN BENEFITS 5
5.01 Coverage Options 5
5.02 Benefits 5
5.03 Payment of Benefits 5
5.04 Duration of Benefits 5
5.05 Designation of Beneficiaries 5

ARTICLE VI GENERAL EXCLUSIONS 5

ARTICLE VII SUBROGATION 5

ARTICLE VIII ADMINISTRATION OF PLAN 5
8.01 Committee and Insurer to Administer the Plan 5
8.02 The Committee 6
8.03 Powers of the Plan Administrator 6
8.04 Interpretative Authority 6

ARTICLE IX CLAIMS FOR BENEFITS 7
9.01 Claims Procedures 7

ARTICLE X CESSATION OF PARTICIPATION 7
10.01 Cessation of Participation 7

ARTICLE XI MISCELLANEOUS PROVISIONS 8
11.01 Assignment of Benefits 8
11.02 Information to Be Furnished 8
11.03 Limitation of Rights 8
11.04 Plan Not Contract 8
11.05 Fiduciary Operation 8
11.06 No Guaranty 8
11.07 Misrepresentation 8
11.08 Inadvertent Error 9
11.09 No Limitation of Management Rights 9
11.10 Participant Responsibilities 9
11.11 Right of Recovery 9
11.12 Governing Law and Venue 9
11.13 Severability 9
11.14 Participant Litigation 9
11.15 Counterparts 10
11.16 Notice 10
11.17 Extension of Plan to Related Employers 10

ARTICLE XII FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 10
12.01 Fully-Insured Plan 10
12.02 Amendment 10
12.03 Termination 10
12.04 Collective Bargaining Agreement 11

ARTICLE I
INTRODUCTION

1.01 **Purpose of Plan**. Columbia Energy Group established and maintained the Columbia Energy Group Long Term Disability Benefit Plan to provide long-term disability benefits for the participants and beneficiaries thereunder. Effective as of January 1, 2004, the Columbia Energy Group Long Term Disability Benefit Plan was amended and restated, was broadened to include coverage for the former participants of one or more long-term disability plans sponsored by NiSource Inc. (the "Company") or an affiliate, was renamed the NiSource Long-Term Disability Plan, and as of such date and continuing thereafter, was sponsored and maintained by the Company. The Plan was further amended and restated effective as of January 1, 2008, at which time it became a component welfare plan of the NiSource Welfare Benefits Program, and was amended and restated again effective January 1, 2010, January 1, 2013, January 1, 2014, and January 1, 2015. This is an amended and restated version of the Plan, effective as of the Separation Date (defined below), that reflects certain plan design changes in connection with the CPG Spin-Off (defined below).

ARTICLE II
DEFINITIONS

2.01 **Annual Enrollment Period**. "Annual Enrollment Period" means the period selected by the Company each year during which time an Employee may select Plan coverage to be effective for the following Plan Year.

2.02 **Applicable Group Insurance Certificate**. "Applicable Group Insurance Certificate" means a group insurance certificate issued by an Insurer that is applicable to the group of employees to which a Participant belongs. Each Applicable Group Insurance Certificate is subject in every way to the group insurance contract or contracts issued by the Insurer that fund Plan benefits, which contract or contracts include the Applicable Group Insurance Certificate.

2.03 **Applicable SPD**. "Applicable SPD" means the summary plan description applicable to the group of employees to which a Participant belongs. Each Applicable SPD shall be consistent with the group insurance contract or contracts issued by the Insurer that fund Plan benefits and with the Applicable Group Insurance Certificate. To the extent that an Applicable SPD is inconsistent with the group insurance contract or contracts or with the Applicable Group Insurance Certificate, the terms of the group insurance contract or contracts and the Applicable Group Insurance Certificate shall control.

2.04 **Code**. "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.05 **Committee**. "Committee" means the NiSource Benefits Committee or its predecessor, the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

2.06 **Company**. "Company" means NiSource Inc., a Delaware corporation.

2.07 **CPG**. "CPG" means Columbia Pipeline Group, Inc., a Delaware corporation.

2.08 **CPG Related Employer**. "CPG Related Employer" means, on and after the Separation Date, (1) any corporation that is a member of a controlled group of corporations (as defined in Section

414(b) of the Code) that includes CPG; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with CPG; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes CPG.

2.09 **CPG Spin-Off**. "CPG Spin-Off" means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG.

2.10 **CPG Spin-Off Employee**. CPG Spin-Off Employee means an employee of CPG or of a CPG Related Employer who was covered under this Program immediately prior to the Separation Date and who became ineligible for such coverage in connection with the CPG Spin-Off.

2.11 **Employee**. "Employee" means an employee of an Employer, provided such employee is eligible for coverage under an Applicable Group Insurance Certificate. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.12 **Employer**. "Employer" means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer, to the extent an employee welfare benefit plan providing long-term disability benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.08, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

2.13 **ERISA**. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.14 **FMLA**. "FMLA" means the Family and Medical Leave Act of 1993, as amended.

2.15 **Insurer**. "Insurer" means an insurance carrier selected by the Plan Administrator or the Plan to issue one or more policies that insure Plan benefits.

2.16 **Participant**. "Participant" means each Employee who is covered under the Plan.

2.17 Plan. "Plan" means the NiSource Long-Term Disability Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.19 Plan Year. "Plan Year" means the calendar year.

2.20 Related Employer. "Related Employer" means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company, (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company, and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.21 Represented. "Represented" means an Employee who is covered by a collective bargaining agreement between an Employer and a union.

2.22 Separation Date. "Separation Date" means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

2.23 Status Change. "Status Change" means any of the following:

(a) *Employment status.* A termination or commencement of employment by an Employee;

(b) *Work Schedule.* A reduction or increase in hours of employment by a Participant, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence;

(c) *Residence or Worksite.* A change in the place of residence or work of an Employee; and

(d) *Other.* Any other event determined to be a Status Change under the Code or any regulation, ruling or release issued thereunder.

2.24 Construction. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise. Any term used but not otherwise defined herein shall have the meaning given such term in the Applicable Group Insurance Certificate.

ARTICLE III
PARTICIPATION

3.01 Eligibility. Each Employee of an Employer may be covered under the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate.

3.02 Enrollment.

(a) *New Hires.* With respect to a coverage option for which an Employee does not any make contributions to the cost of coverage ("noncontributory coverage"), each Employee who becomes eligible under the Plan shall automatically be enrolled for coverage in accordance with the terms of the Applicable Group Insurance Certificate. With respect to

a coverage option for which an Employee must make contributions to the cost of coverage ("contributory coverage"), as a condition of participation in such coverage option under the Plan, each Employee who becomes eligible for such coverage shall properly enroll on or before the 31st day after the Employee first becomes eligible. Subject to the terms of the Applicable Group Insurance Certificate, such enrollment shall be effective for the period beginning on the first day of eligibility and ending on the last day of the Plan Year in which such participation begins. An Employee who becomes eligible for, but fails to properly enroll in, Option Two under the Plan, referred to in Section 5.01 below, shall be deemed to have enrolled in Option One, also referred to in Section 5.01 below.

(b) *Annual Enrollment Period.* An Employee eligible for coverage under the Plan may enroll for coverage or change coverage options by properly enrolling during the Annual Enrollment Period. Such election or change shall be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year; provided, however, if such Employee makes no election or change during the Annual Enrollment Period, such Employee shall be deemed to have elected to continue his or her existing coverage.

(c) *Status Change Enrollment.* With respect to any contributory coverage, if a Status Change occurs, an Employee eligible for coverage may change his or her enrollment during the Status Change Enrollment Period provided under this subsection; provided, however, if required by Section 125 of the Code and the regulations, rulings and releases issued thereunder, such change in coverage shall be consistent with the Status Change event. Such Status Change Enrollment Period shall begin on the date of the Status Change event, and shall expire 31 days thereafter. Accordingly, to obtain or modify coverage under this subsection, the eligible Employee shall properly modify his or her enrollment during such Status Change Enrollment Period. Coverage under this subsection shall be effective as of the date an enrollment change is approved by the Insurer and the Plan Administrator. Any change in enrollment as a result of a Status Change event shall be subject to any applicable requirements or limitations imposed by Section 125 of the Code and the regulations, rulings and releases issued thereunder, and to any additional requirements or limitations set forth in the Applicable Group Insurance Certificate.

(d) *Evidence of Insurability.* To the extent required by the Insurer, Participants shall submit evidence of insurability. The Insurer shall have the right to approve or deny any coverage in its sole discretion as a result of such submission or refusal to submit.

ARTICLE IV
CONTRIBUTIONS TO THE PLAN

4.01 Participant Contributions. As a condition of participation, a Participant shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company.

4.02 Employer Contributions. The Employer will contribute to the cost of the Plan to the extent such cost exceeds the amount contributed by the Participant.

ARTICLE V
PLAN BENEFITS

5.01 **Coverage Options.** Subject to the terms of the Applicable Group Insurance Certificate, Employees may choose from one of two coverage options under the Plan: Option One and Option Two. Option One shall provide 50 percent replacement of a Participant's monthly earnings, subject to limitations set forth in the Applicable Group Insurance Certificate. Option Two shall provide 60 percent replacement of a Participant's monthly earnings, subject to limitations set forth in the Applicable Group Insurance Certificate. "Monthly earnings" or the equivalent term shall be defined in the Applicable Group Insurance Certificate.

5.02 **Benefits.** Eligibility for benefits under the Plan shall be determined pursuant to the Applicable Group Insurance Certificate.

5.03 **Payment of Benefits.** Benefits shall be paid by the Insurer pursuant to the Applicable Group Insurance Certificate.

5.04 **Duration of Benefits.** The maximum period for which benefits may be paid under the Plan shall be set forth in the Applicable Group Insurance Certificate.

5.05 **Designation of Beneficiaries.** Each Participant from time to time may name a beneficiary under the Plan in accordance with procedures established by the Insurer. All determinations of the identity of any beneficiary shall be made by the Insurer. If a Participant fails to designate a beneficiary before his or her death or if the designated beneficiary dies before the date of the Participant's death or before complete payment of the Participant's benefits, Plan benefits shall be payable in accordance with procedures established by the Insurer.

ARTICLE VI
GENERAL EXCLUSIONS

The Plan shall not provide coverage for any exclusions set forth in the Applicable Group Insurance Certificate.

ARTICLE VII
SUBROGATION

All Participants shall be subject to any subrogation and any third-party recovery provisions as may be established by the Insurer.

ARTICLE VIII
ADMINISTRATION OF PLAN

8.01 **Committee and Insurer to Administer the Plan.** The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA. The Insurer shall be the Plan fiduciary responsible for all claims decisions, including appeals of denied claims.

8.02 **The Committee**. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

8.03 **Powers of the Plan Administrator**. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Participants;

(d) To direct the Insurer to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine the status and rights of all Participants;

(h) To make regulations and prescribe procedures;

(i) To obtain from the Company, Participants and others, such information as is necessary for the proper administration of the Plan;

(j) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(k) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(l) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

8.04 **Interpretative Authority**. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan, the Applicable Group Insurance Certificates and the Applicable SPDs. Any writing, decision or other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Insurer decides in its discretion that the applicant is entitled to them, in accordance with provisions of the Plan and the Applicable Group Insurance Certificates.

ARTICLE IX
CLAIMS FOR BENEFITS

9.01 Claims Procedures. All claims for benefits and appeals of denied claims shall be decided by the Insurer in accordance with the procedures contained in the Applicable SPD, which are incorporated herein by this reference.

ARTICLE X
CESSATION OF PARTICIPATION

10.01 Cessation of Participation. Except as otherwise provided in this Article, a Participant shall cease to participate in the Plan on the earliest of the following dates:

(a) The date as of which the Plan is terminated;

(b) The date the group insurance contract or contracts that fund Plan benefits are canceled;

(c) The date that the Plan is amended to terminate coverage with respect to a Participant;

(d) The date the Participant is no longer a member of a class covered under, or the date the Participant's class is no longer covered under, the Applicable Group Insurance Certificate, including without limitation as a result of the Participant's employer no longer being a Related Employer;

(e) The date that a Participant terminates employment, except that if such Participant is disabled as defined in the Plan when employment terminates, coverage and benefits will continue as provided in the Applicable Group Insurance Certificate;

(f) The date a Participant is no longer in active employment due to a disability that is not covered under the Plan or is otherwise no longer eligible for coverage under the Plan;

(g) The date a Participant commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided by the NiSource Military Leave of Absence Policy;

(h) The last date for which any required Participant contribution was made;

(i) The date a Participant is no longer in active employment, except as provided below in this Section 10.01 and except to the extent continuation coverage is required by the FMLA; and

(j) Any other date set forth in the Applicable Group Insurance Certificate as of which participation shall cease.

If a Participant is on a temporary layoff or is working reduced hours for reasons other than disability and the premium for coverage under the Plan is paid, the Participant will be covered to the end of the month following the month in which the Participant's temporary layoff or reduced hours began. Except to the extent the FMLA requires a longer period of continuation coverage, if a Participant is on a leave of absence and the premium for coverage under the Plan is paid, a Participant will be covered to the end of the month in which the Participant's leave begins.

Neither temporary layoff nor leave of absence includes normal vacation time or any period of disability or absence in connection with any severance or termination agreement. Leave under the FMLA is also not considered a temporary layoff.

Without limiting the generality of the foregoing, a CPG Spin-Off Employee receiving benefits under the Plan immediately prior to the Separation Date shall not be entitled to any further benefits hereunder as of the Separation Date.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.01 Assignment of Benefits. A Participant may assign benefits to the extent permitted by the Insurer.

11.02 Information to Be Furnished. A Participant shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant any legal or equitable right against the Company or any Employer, except as provided herein.

11.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

11.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

11.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only by the Insurer.

11.07 Misrepresentation. Any material misrepresentation on the part of any Participant in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void.

11.08 Inadvertent Error. Subject to the terms of the Applicable Group Insurance Certificate, inadvertent error by the Plan Administrator in the keeping of records or the transmission of any enrollment shall not deprive any Participant of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

11.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the rights of the Company or of any Employer to discipline or terminate an Employee.

11.10 Participant Responsibilities. Each Participant is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Insurer shall have any obligation or duty to locate a Participant. If a Participant becomes entitled to a payment under the Plan and it cannot be made because (1) the Participant's current address is incorrect, (2) the Participant does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

11.11 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization.

11.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 11.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

11.13 Severability. In the event any portion of the Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of the Plan, and the balance of the Plan shall remain in full force and effect.

11.14 Participant Litigation. In any action or proceeding involving the Plan, Participants or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results adversely to such person or,

if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Participant or other person concerned. To the extent permitted by applicable law, an election to become a Participant under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

11.15 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

11.16 Notice. Any notice given under the Plan shall be sufficient, if given to the Plan Administrator, when addressed to it at its office; if given to the Insurer, when addressed to it at its office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Insurer.

11.17 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XII
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

12.01 Fully-Insured Plan. The Plan is a fully-insured plan. All contributions related to the Plan are used to pay insurance premiums and related expenses thereunder.

12.02 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Unless expressly provided, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect.

12.03 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

12.04 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article XII, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 22nd day of June, 2015, to be effective as of the Separation Date.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

NISOURCE
SHORT-TERM DISABILITY PLAN

As Amended and Restated
Effective as of January 1, 2017

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1

ARTICLE II DEFINITIONS 1
2.01 Actively at Work 1
2.02 Claims Administrator 1
2.03 Code 1
2.04 Committee 1
2.05 Company 1
2.06 Disability 1
2.07 Disability Management Program 1
2.08 Employee 1
2.09 Employer 1
2.10 ERISA 2
2.11 Injury 2
2.12 NIPSCO 2
2.13 Other Income Benefits 2
2.14 Other Party 2
2.15 Partial Disability 2
2.16 Participant 3
2.17 Pay 3
2.18 Physician 3
2.19 Plan 3
2.20 Plan Administrator 3
2.21 Plan Effective Date 3
2.22 Plan Year 3
2.23 Related Employer 3
2.24 Represented Employee 3
2.25 Sickness 3
2.26 Total Disability 4
2.27 Years of Service 4
2.28 Construction 5

ARTICLE III PARTICIPATION 5

ARTICLE IV CONTRIBUTIONS TO THE PLAN 5
4.01 Participant Contributions 5
4.02 Employer Contributions 5

ARTICLE V PLAN BENEFITS 5
5.01 Amount of Total Disability Benefits 5
5.02 Amount of Partial Disability Benefits 7
5.03 Commencement of Disability Benefits 7
5.04 Recurring or Separate Periods of Disability 7
5.05 Coordination with Other Income Benefits 7
5.06 Disability Management Program 8
5.07 Payment of Benefits 9
5.08 Duration of Benefit Payments 9

5.09 Designation of Beneficiaries....10
5.10 Facility of Payment....10

ARTICLE VI GENERAL EXCLUSIONS....10

ARTICLE VII SUBROGATION....10
7.01 Subrogation....10
7.02 Right of Recovery....11
7.03 Cooperation Required....11
7.04 First Lien Created....11
7.05 Personal Liability Created....11

ARTICLE VIII ADMINISTRATION OF PLAN....11
8.01 Company to Administer the Plan....11
8.02 The Committee....11
8.03 Powers of the Plan Administrator....12
8.04 Interpretative Authority....12
8.05 Appointment of the Claims Administrator....13

ARTICLE IX CLAIMS FOR BENEFITS....13
9.01 Filing Initial Claim....13
9.02 Consideration of Initial Claim....13
9.03 If the Claims Administrator Denies the Initial Claim....13
9.04 Appeal to the Claims Administrator....13
9.05 If the Claims Administrator Denies the Claim on Appeal....14
9.06 Appeal to the Plan Administrator....15
9.07 If the Plan Administrator Denies the Claim on Appeal....15
9.08 Legal Actions....16
9.09 Physical Examinations....16
9.10 Construction of Article....16

ARTICLE X TERMINATION OF PARTICIPATION....16
10.01 Cessation of Participation....16
10.02 Severance....17

ARTICLE XI MISCELLANEOUS PROVISIONS....17
11.01 Assignment of Benefits....17
11.02 Information to Be Furnished....17
11.03 Limitation of Rights....17
11.04 Plan Not Contract....17
11.05 Fiduciary Operation....17
11.06 No Guaranty....17
11.07 Misrepresentation....18
11.08 Inadvertent Error....18
11.09 No Limitation of Management Rights....18
11.10 Participant Responsibilities....18
11.11 Right of Recovery....18
11.12 Governing Law and Venue....18
11.13 Severability....18
11.14 Participant Litigation....18
11.15 Counterparts....19

11.16 Notice....19
11.17 Extension of Plan to Related Employers....19

ARTICLE XII FUNDING, AMENDMENT AND TERMINATION OF THE PLAN....19
12.01 Plan Self Insured....19
12.02 Participants' and Dependents' Rights Unsecured....19
12.03 Amendment....19
12.04 Termination....20
12.05 Collective Bargaining Agreement....20

ARTICLE I
INTRODUCTION

Columbia Energy Group established and maintained the Columbia Energy Group Sick Leave Plan to provide short-term disability benefits for the participants and beneficiaries thereunder. Effective as of the Plan Effective Date, the Columbia Energy Group Sick Leave Plan was broadened to include coverage for the former participants of one or more short-term disability plans sponsored by NiSource Inc. (the "Company") or an affiliate, was renamed the NiSource Short-Term Disability Plan (the "Plan"), and from such date forward, has been sponsored and maintained by the Company. The Plan was amended from time to time after the Plan Effective Date and was amended and restated effective as of August 14, 2012, as of January 1, 2015, and as of January 1, 2016. This is an amendment and restatement of the Plan effective as of January 1, 2017.

ARTICLE II
DEFINITIONS

2.01 **Actively at Work.** "Actively at Work" means, for each day that is one of the Employer's scheduled work days, the Employee performs all of the regular duties of his job for such day. An Employee will be deemed to be Actively at Work on any day that is not one of the Employer's scheduled work days only if he was considered Actively at Work on the preceding scheduled work day.

2.02 **Claims Administrator.** "Claims Administrator" means the person, persons or entity appointed by the Plan Administrator pursuant to Section 8.05.

2.03 **Code.** "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.04 **Committee.** "Committee" means the NiSource Benefits Committee.

2.05 **Company.** "Company" means NiSource Inc., a Delaware corporation.

2.06 **Disability.** "Disability" means Total Disability or Partial Disability.

2.07 **Disability Management Program.** "Disability Management Program" means the program described in Section 5.06 below.

2.08 **Employee.** "Employee" means a regular, Full-time employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.09 **Employer.** "Employer" means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that an employee welfare benefit plan providing short-term disability benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related

Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations.

2.10 ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.11 Injury. "Injury" means a bodily injury that is the direct result of an accident, that is not related to any cause other than the accident, the results in immediate disability, and that requires treatment by a Physician. Disability resulting from an Injury must begin while a Participant is covered under the Plan.

2.12 NIPSCO. "NIPSCO" means Northern Indiana Public Service Company.

2.13 Other Income Benefits. "Other Income Benefits" means the amount of any benefit for loss of income, provided to a Participant, as a result of the period of Disability for which benefits are paid under the Plan. This includes any such benefits for which the Participant is eligible, or that are paid to the Participant, or to a third party on his or her behalf. This includes, but is not limited to, the amount of any benefit for loss of income for the same Disability from: (1) the United States Social Security Act, the Railroad Retirement Act, the Jones Act, or similar plan or act that the Participant is eligible to receive because of his or her Disability; (2) the Veteran's Administration or any other foreign or domestic governmental agency for the same Disability; (3) any governmental law or program that provides disability or unemployment benefits as a result of the Participant's employment with an Employer, including any state disability program; (4) any temporary or permanent disability benefits under a Workers' Compensation law, occupational disease law, or similar law; and (5) compulsory "no-fault" automobile insurance.

2.14 Other Party. "Other Party" includes, without limitation, any of the following:

(a) Any party or parties who caused a Disability;

(b) Any insurer or other indemnifier of the party or parties who caused a Disability;

(c) Any guarantor of the party or parties who caused a Disability;

(d) A Participant's insurer;

(e) A Workers' Compensation insurer; or

(f) Any other person, entity, policy or plan that is liable or legally responsible in relation to a Participant's Disability.

2.15 Partial Disability. "Partial Disability" means a Participant's mental or physical inability, due to Sickness or Injury, to perform the essential functions of his or her own occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience, on a full-time basis. The loss of any professional license or certification required for a Participant's occupation does not, in and of itself, constitute a 'Partial Disability.' "Essential functions" means functions

that (i) are normally required for performance of a Participant's occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience, and (ii) cannot be reasonably omitted or modified.

2.16 **Participant.** "Participant" means each Employee who is covered under the Plan.

2.17 **Pay.** "Pay" means basic earnings inclusive of sales commissions plus any before tax deposits deferred by an Employee pursuant to any qualified retirement plan sponsored by the Company or an affiliate, or any successor plans thereto, but not including overtime, shift differentials, bonus or any other form of special compensation. For employees receiving sales commissions, "Pay" shall mean the average hourly wage based on the 12 consecutive calendar months immediately preceding the last day Actively at Work.

2.18 **Physician.** "Physician" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. Doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, optometrists, and chiropractors shall be deemed to be Physicians when acting within the scope of their license. A person who has a doctoral degree in psychology (Ph.D or Psy.D) and whose primary practice is treating patients shall also be deemed to be a Physician. A Physician shall not include any relative of a Participant, including without limitation a Participant's spouse, child, brother, sister or parent.

2.19 **Plan.** "Plan" means the NiSource Short-Term Disability Plan set forth herein, together with any and all amendments and supplements thereto.

2.20 **Plan Administrator.** "Plan Administrator" means the Committee and any persons or entities to whom the Committee has from time to time delegated authority to carry out the administrative functions of the Plan. The Committee has delegated to the Manager, HR Benefits, the Director Corporate Insurance and the Vice President Human Resources the authority to decide appeals of denied claims on behalf of the Plan Administrator pursuant to Sections 9.06 and 9.07. Such appeals shall be decided by the Manager, HR Benefits and the Director Corporate Insurance. In the event such persons do not agree on the decision with respect to an appeal, the Vice President Human Resources shall decide such appeal.

2.21 **Plan Effective Date.** "Plan Effective Date" means January 1, 2004.

2.22 **Plan Year.** "Plan Year" means the calendar year.

2.23 **Related Employer.** "Related Employer" means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company, (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company, and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.24 **Represented Employee.** "Represented Employee" means an Employee who is covered by a collective bargaining agreement between an Employer and a union.

2.25 **Sickness.** "Sickness" means a disease, disorder or condition of the body or mind, including pregnancy, abortion, miscarriage or childbirth, that requires treatment by a Physician, but does not include an Injury. Disability resulting from a Sickness must begin while a Participant is covered under the Plan.

2.26 Total Disability. "Total Disability" means a Participant's mental or physical inability, due to Sickness or Injury, to perform the essential functions of his or her own occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience. The loss of any professional license or certification required for a Participant's occupation does not, in and of itself, constitute a 'Total Disability.' "Essential functions" means functions that (i) are normally required for performance of a Participant's occupation or any job requiring similar education or training that an Employer offers him or her, for which he or she is reasonably qualified by reason of his or her education, training, or experience, and (ii) cannot be reasonably omitted or modified.

2.27 Years of Service. "Years of Service" means a Participant's 12-month period of employment with an Employer, determined as follows: a Participant's first Year of Service is counted from the Participant's date of hire to his or her first anniversary with an Employer. After the Participant's first anniversary with an Employer, Years of Service are calculated on a calendar year basis. Thus, on the December 31 following a Participant's first anniversary with an Employer, and on each subsequent December 31 thereafter, a Participant will be credited with an additional Year of Service. A Participant must be Actively at Work at least one day in a calendar year to be credited with an additional Year of Service for that year under the Plan.

A Participant who terminated employment, or who retired from employment, with an Employer, and who is thereafter rehired by an Employer, shall receive credit for Years of Service as follows:

Less than one year after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, including time of break
At least one year, but less than five years, after termination of employment or retirement from employment	All service prior to termination of employment or retirement from employment, but excluding time during break in service.
At least five years after termination of employment or retirement from employment	No service credit. Participant begins with zero Years of Service upon rehire.

A Participant (i) who was an active employee of Columbia Pipeline Group, Inc. or its affiliates as of July 1, 2015, (ii) who terminated employment, or who retired from employment, with Columbia Pipeline Group, Inc. or its affiliates on or after July 1, 2015, and (iii) who is thereafter rehired by an Employer, shall receive credit for Years of Service as follows:

On or after July 1, 2015 and before July 1, 2016	All service with an Employer from the date of original hire prior to July 1, 2015 to and including the date of rehire by an Employer on or after July 1, 2015.
On or after July 1, 2016 and before July 1, 2020	All service with an Employer from the date of original hire prior to July 1, 2015, to and including June 30, 2015
On or after July 1, 2020	No service credit. Participant begins with zero Years of Service upon rehire.

2.28 **Construction.** A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

ARTICLE III
PARTICIPATION

Each regular, Full-time Represented Employee of an Employer, other than a NIPSCO Represented Employee, and each Full-time Employee of an Employer who is not a Represented Employee and who was hired before January 1, 2017, will be covered under the Plan on the first day of the month coincident with or next following his or her completion of 6 continuous months of active, Full-time employment with an Employer. Each regular, Full-time Employee of an Employer who is not a Represented Employee and who was hired on or after January 1, 2017, will be covered under the Plan as of his or her first day of active, Full-time employment with an Employer. A "Full-time Employee" or "Full-time Represented Employee" is an Employee characterized by an Employer as a full-time employee who regularly works 40 hours per week. For new hires, such Employee must be Actively at Work on the date coverage is scheduled to begin. For purposes of the Plan, the terms "NIPSCO Represented Employee" and "Represented Employee" shall not include any Employee employed by NIPSCO in the role of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) (hereinafter, "Damage Prevention Coordinator") during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and NIPSCO with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019, unless such Employee was considered a NIPSCO Represented Employee immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator. Effective as of May 1, 2019, Employees employed by NIPSCO in the position of Damage Prevention Coordinator shall be considered NIPSCO Represented Employees for purposes of the Plan, unless otherwise negotiated in an agreement between the bargaining unit and NIPSCO.

ARTICLE IV
CONTRIBUTIONS TO THE PLAN

4.01 **Participant Contributions.** As a condition of participation, a Participant shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company.

4.02 **Employer Contributions.** The Employer will contribute to the cost of the Plan to the extent such cost exceeds the amount contributed by the Participant.

ARTICLE V
PLAN BENEFITS

5.01 **Amount of Total Disability Benefits.**

(a) Represented Employees and Non-Represented Employees Hired Before January 1, 2017. A Participant who is (a) a Full-time Represented Employee (other than a NIPSCO Represented Employee) of an Employer, or (b) a Full-time Employee, but not a Represented Employee, of an Employer and who was hired before January 1, 2017, shall be entitled to a weekly benefit for the first 26 weeks of Total Disability based on his or her Pay and Years of Service as of the January 1st immediately prior to the date of Total Disability (except (i) for an Employee with more than six months and less than one Year of Service, in which case Pay and Years of Service shall be determined as of the date of

Disability, and (ii) for a rehired Employee who is entitled to credit for prior Years of Service, in which case, in the year of rehire, Pay shall be determined as of the date of Disability and Years of Service shall be determined as of the date of rehire), in accordance with the following schedule:

More than 6 months (0.5 years) but less than 1 year from date of hire	1 week	0 weeks
1 year to 9 years	8 weeks	18 weeks
10 years to 19 years	16 weeks	10 weeks
20 years or more	26 weeks	0 weeks

(b) Non-Represented Employees Hired On or After January 1, 2017. A Participant who is a Full-time Employee of an Employer, but is not a Represented Employee, and who is hired on or after January 1, 2017, shall be entitled to a weekly benefit for the first 26 weeks of Total Disability based on his or her Pay and Years of Service as of the January 1st immediately prior to the date of Total Disability (except that in the year an Employee is hired or rehired, Pay shall be determined as of the date of Disability and the calendar quarter in which the Employee was hired or rehired shall be substituted for Years of Service, unless the Employee is entitled to credit upon rehire for prior Years of Service, in which case Years of Service shall be determined as of the date of rehire), in accordance with the following schedule:

Hired (or rehired with no credit for prior Years of Service) in 1st quarter of calendar year	4 days	0 days
Hired (or rehired with no credit for prior Years of Service) in 2nd quarter of calendar year	3 days	0 days
Hired (or rehired with no credit for prior Years of Service) in 3rd quarter of calendar year	2 days	0 days
Hired (or rehired with no credit for prior Years of Service) in 4th quarter of calendar year	1 day	0 days
January 1 after date of hire (or after date of rehire with no credit for prior Years of Service) to 9 years	8 weeks	18 weeks
10 years to 19 years	16 weeks	10 weeks
20 years or more	26 weeks	0 weeks

(c) Payment and Duration of Benefits, Generally. The amount of benefit determined on a weekly basis shall be paid on a basis consistent with the Employer's payroll periods. In no instance will the benefit under the Plan extend beyond the Participant's normal retirement date as defined in any qualified retirement plan sponsored by the Company or an affiliate, or any successor plan, or the date benefits commence under the NiSource Long-Term Disability Plan.

If a Participant is receiving weekly benefits on account of a Total Disability as of the end of a calendar year and is unable to return to work as of the beginning of the next calendar

year, such Participant will continue to be entitled to the weekly benefits under the Plan to which he or she was otherwise entitled for the previous calendar year, subject to the other terms, conditions and limitations of the Plan. Subject to Section 5.04 below, such Participant will not be entitled to additional weekly benefits under the Plan until he or she returns to work for one full day in the next calendar year.

5.02 **Amount of Partial Disability Benefits.** A Participant shall be entitled to a weekly benefit, paid on a basis consistent with the Employer's payroll periods, for the first 26 weeks of Partial Disability based on a percentage of his or her Total Disability benefit (described in Section 5.01). The percentage of the Total Disability benefit for which a Participant shall be entitled under this Section shall equal 100 percent of his or her Total Disability benefit minus the percentage of Pay the Participant actually receives from an Employer for the performance of his or her own occupation during that period, determined on a weekly basis. If a Participant is Partially Disabled, he or she may be assigned temporary modified work, which assignment must be approved by the Participant's personal Physician, a Physician appointed by the Company (where appropriate) and the Participant's supervisor.

5.03 **Commencement of Disability Benefits.**

(a) Submission of Claim. The Participant must apply to the Claims Administrator, in the manner determined by the Plan Administrator and the Participant's supervisor, to commence benefit payments under the Plan. The Participant shall provide, or cause to be provided, such proof of Disability as is required by the Claims Administrator in accordance with written procedures which shall be incorporated herein by this reference. Without limiting the generality of the foregoing, if a Participant is absent from work for more than four consecutive days, the Participant must be under the regular care of a Physician and must furnish proof of Disability to the Claims Administrator.

(b) Commencement of Benefits. Upon approval by the Claims Administrator of the Participant's claim, benefits payable pursuant to this Article V shall commence on the first calendar day of the Participant's absence due to Disability, measured from the last day he or she is Actively at Work.

5.04 **Recurring or Separate Periods of Disability.** If a Participant is collecting Plan benefits due to a Disability, temporarily recovers and returns to work for an Employer for 180 consecutive calendar days or less, and then again incurs a Disability due to the same or a related illness or injury, the Participant's subsequent Disability is considered a recurring Disability. In such case, the Participant will be entitled to benefits for the recurring Disability for the maximum benefit period under the Plan, less the benefits the Participant has already received for that Disability.

If a Participant is collecting Plan benefits due to a Disability, temporarily recovers and returns to work for an Employer for 181 or more consecutive calendar days, and then again incurs a Disability due to the same or a related illness or injury, the Disability is considered a separate Disability. In such case, the Participant will be entitled to benefits for the separate Disability for the maximum benefit period and such amount will not be reduced by the benefits the Participant has already received for that Disability. Provided, however, that a Participant will not be entitled to benefits under the Plan during a calendar year in excess of the benefits applicable to such Participant described in Section 5.01 above.

5.05 **Coordination with Other Income Benefits.** A Participant may be eligible for Other Income Benefits with respect to the period of time for which benefits are payable under the Plan. In such case, benefits under the Plan shall be fully offset by such Other Income Benefits. If a Participant

is paid Other Income Benefits in a lump sum, the amount of offset to the weekly benefit amount will be determined by prorating the lump sum over a period of 26 weeks.

5.06 Disability Management Program.

(a) General. As a condition of receiving benefits under the Plan, a Participant must participate in, and comply with all requirements of, the Disability Management Program. The Disability Management Program certifies that a Participant qualifies for benefits under the Plan beyond the fourth day of absence from work and develops a return to work plan in consultation with the Participant and his or her Physician and supervisor.

(b) Program Requirements. As a part of the Disability Management Program, each Participant must

(i) supply the authorization and documentation described in Section 5.06(c);

(ii) maintain contact with the Claims Administrator;

(iii) follow the medical treatment plan agreed to by the Claims Administrator and the Participant's Physician; and

(iv) return to work at the time that is agreed to by the Participant, the Claims Administrator, the Participant's and the Participant's supervisor.

(c) Required Authorization and Documentation. Each Participant must provide all information requested by the Claims Administrator, including without limitation the following:

(i) a signed authorization form for the Claims Administrator to obtain all reasonably necessary medical, financial, or other non-medical information that supports the Participant's Disability claim;

(ii) proof that the Participant has applied for other sources of disability income (e.g., Workers' Compensation, State Disability Benefits, or Social Security Disability Benefits, when applicable); and

(iii) Written notification when the Participant receives or is awarded a benefit from another source of disability income, which notice shall include the following information:

(A) the type of income benefit;

(B) the amount the Participant is receiving;

(C) the period for which the benefit applies; and

(D) the duration for which the benefit is being paid (if the Participant is receiving installment payments).

(d) Release in Connection with Return to Work. Upon request, the Participant shall furnish to the Company and to the Claims Administrator a release from the Participant's Physician, satisfactory to the Company and to the Claims Administrator, as a condition of returning to work after a Disability.

5.07 **Payment of Benefits**. All benefits shall be paid directly to the Participant, or if the Participant is deceased, in accordance with Section 5.09. Benefits may be paid directly from the general assets of the Company or from any other lawful funding vehicle as may be established by the Company.

5.08 **Duration of Benefit Payments**. This Plan provides benefits for a maximum of 26 weeks during a period of Disability. Subject to Section 5.03, the duration of benefit payments is measured from the last day the Participant is Actively at Work.

Benefit payments shall terminate prior to the conclusion of 26 weeks if the Participant's Disability ends. Benefit payments shall also terminate if any of the following events occur, as determined by the Plan Administrator or the Claims Administrator:

(a) Failure to Provide Required Information. The Participant fails to submit evidence of Disability or such other documents that the Plan Administrator or Claims Administrator deems necessary to administer the Plan, in accordance with written procedures that shall be incorporated herein by this reference.

(b) Failure to Submit Evidence or Refusal of Examination. The Participant does not submit or cause to be submitted on his or her behalf evidence of continuing Disability that has been requested or the Participant refused an independent medical examination or other examinations or tests requested by the Plan Administrator or the Claims Administrator to determine whether the Participant has a continuing Disability.

(c) Other Occupation. The Participant is engaged in any other occupation or earns any self-employment income in excess of a de minimis amount.

(d) Failure to Comply with Physician's Requirements. The Participant is not under the regular care of a Physician as required by his or her condition or the Participant is not following the Physician's treatment plan.

(e) Failure to Perform Temporary Modified Work Assignment. In the case of a Partial Disability, the Participant fails or refuses to perform any temporary modified work assignment.

(f) Failure to Comply with Disability Management Program Requirements. The Participant fails to participate in or comply with all requirements of the Disability Management Program, including without limitation providing all required documentation regarding the Participant's Disability.

(g) Participant in a Felony. The Participant participates in and is convicted of a felony offense. In such case, the Participant's Disability shall be determined to have ceased as of the date that the Participant first participated in such felony offense.

(h) Fraud. The Participant commits or partakes in any actions of fraud against the Plan, an Employer, or the Committee.

(i) Termination of Employment. The Participant has been terminated or voluntarily terminates employment with the Employer (other than transfer to a Related Employer), or dies.

(j) Termination of Participant. The Participant's participation in the Plan terminates pursuant to Section 10.01.

5.09 **Designation of Beneficiaries.** If a Participant dies before he or she receives all of the benefits he or she is entitled to under the Plan, the Plan Administrator shall pay such benefits to the Participant's spouse, or if no spouse is living, to his or her beneficiary under any life insurance plan (as selected by the Plan Administrator) sponsored by the Company or an affiliate, or if none, to the legal representative of the estate of the Participant, or if none is appointed within 6 months after the date of his or her death, to his or her heirs under the laws of the state in which he or she is domiciled at the date of his or her death.

5.10 **Facility of Payment.** When a person entitled to benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the Plan.

ARTICLE VI
GENERAL EXCLUSIONS

Notwithstanding any other Plan provision to the contrary, in no event shall benefits be payable under the Plan with respect to the following categories of Disability of a Participant:

(a) Disability not being treated by a Physician;

(b) Disability caused or contributed to by war or an act of war (declared or not);

(c) Disability caused by the Participant's commission of or attempt to commit a crime for which the Participant has been convicted, or to which a contributing cause was the Participant's being engaged in an illegal occupation;

(d) Disability caused or contributed to by an intentionally self-inflicted injury; and

(e) Disability incurred while the Participant is on a leave of absence, furlough, suspension from work, or in a status other than that of Actively at Work. In such case, benefits will only commence on the date the Participant was expected to return to an Actively at Work status provide the Participant is still disabled.

ARTICLE VII
SUBROGATION

7.01 **Subrogation.** If an Other Party is liable or legally responsible to pay expenses, compensation and/or damages in relation to a Disability incurred by any Participant, and benefits are payable under the Plan in relation to such Disability, the Plan shall be subrogated to all rights of recovery of such Participant. The Participant or his or her legal representative shall transfer to the Plan any rights he or she may have to take legal action arising from the Disability so that the Plan may recover any sums paid on behalf of the Participant. If the Participant fails to take legal action against an Other Party, and the Plan elects to take such legal action against such Other Party, in addition to the right to recover Plan benefits paid, the Plan shall be entitled to all expenses, including reasonable attorney's fees, incurred for such recovery. If the Plan recovers an amount greater than Plan benefits paid, the excess, reduced by the expenses of recovery, including reasonable attorney's fees, shall be paid to the Participant. The Plan shall have the right, with

prior notice to, but without the consent of, the Participant, to compromise the amount of its claim if, in the opinion of the Plan Administrator, it is appropriate to do so.

7.02 **Right of Recovery.** The Plan may recover from a Participant or his or her legal representative the amount of any benefits paid under the Plan from any payment the Participant receives or is entitled to receive from an Other Party. The Plan shall not be responsible for any attorney's fees associated with any payment received by a Participant, unless the Plan expressly assumes such obligation prior to the Participant's recovery. Accordingly, unless the Plan expressly agrees otherwise, its recovery shall not be offset by any attorney's fees incurred by a Participant.

7.03 **Cooperation Required.** The Participant or his or her legal representative shall cooperate fully with the Plan in asserting its subrogation and recovery rights. The Participant or his or her legal representative shall, upon request from the Plan, provide all information and sign and return all documents necessary for the Plan to exercise its rights under this provision. No Participant shall take any action to prejudice the Plan's subrogation rights.

7.04 **First Lien Created.** The Company shall have a first lien upon any recovery, whether by settlement, judgment, mediation, arbitration or any other means, that the Participant receives or is entitled to receive from any Other Party. Such lien shall not exceed the lesser of:

(a) the amount of benefits paid by the Plan for the Participant, plus the amount of all future benefits that may become payable under the Plan that result from the Disability. The Plan shall have the right to offset or recover such future benefits from the amount received from the Other Party; or

(b) the amount recovered from the Other Party.

The Company's first lien rights will not be reduced (1) due to the Participant's own negligence, (2) due to the Participant not being made whole, or (3) due to any attorney's fees and costs incurred by the Participant.

7.05 **Personal Liability Created.** If a Participant or his or her legal representative makes any recovery from any Other Party and fails to reimburse the Plan for any benefits paid as a result of the Disability, then (1) the Participant or his or her legal representative shall be personally liable to the Plan for the amount of the benefits paid under the Plan, and (2) the Plan may reduce future benefits payable by the amount of payment that the Participant or his or her legal representative has received from the Other Party. If the Plan institutes legal action against a Participant who fails to reimburse the Plan as required by this Section, in addition to liability to the Plan for the amount of benefits paid under the Plan, such Participant shall be liable to the Plan for the amount of the Plan's costs of collection, including reasonable attorney's fees.

ARTICLE VIII
ADMINISTRATION OF PLAN

8.01 **Company to Administer the Plan.** The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA.

8.02 **The Committee.** The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

8.03 Powers of the Plan Administrator. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Participants;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Plan;

(h) To determine the status and rights of all Participants;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Plan;

(k) To obtain from the Company, Participants and others, such information as is necessary for the proper administration of the Plan;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

8.04 Interpretative Authority. The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Summary Plan Description thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

8.05 **Appointment of the Claims Administrator.** The Plan Administrator shall appoint a Claims Administrator to provide administrative services to the Plan Administrator in connection with the operation of the Plan and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons or entity serving as Claims Administrator shall serve at the pleasure of the Plan Administrator.

ARTICLE IX
CLAIMS FOR BENEFITS

9.01 **Filing Initial Claim.** The entity designated by the Company (the "Claims Administrator") shall process benefit claims pursuant to the procedures set forth below.

9.02 **Consideration of Initial Claim.** The Claims Administrator shall provide notice to a claimant of an adverse benefit determination regarding his or her claim within a reasonable period of time, but generally not later than 45 days after receipt of the claim by the Plan. This 45-day period may be extended for up to 30 days if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a Disability benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information, if any.

9.03 **If the Claims Administrator Denies the Initial Claim.** If the Claims Administrator denies a claim for a Disability benefit in whole or in part, it shall provide the claimant with a written notice of the denial stating (i) the specific reason or reasons for the denial; (ii) reference to the specific Plan provisions on which the denial is based; (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures.

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

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Claims Administrator will provide to the claimant either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

9.04 **Appeal to the Claims Administrator.** If the Claims Administrator denies a claimant's Disability claim in whole or in part, the claimant has the right to appeal the decision by sending a

written request for review to the Claims Administrator within 180 days of his or her receipt of the claim denial notification.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks his or her claim should not have been denied. The request should also include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on his or her claim.

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

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claims Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The Claims Administrator will notify a claimant of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of a claimant's request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination on review.

9.05 **If the Claims Administrator Denies the Claim on Appeal.** If the Claims Administrator denies all or any portion of a claim on appeal, it will notify the claimant in a manner calculated to be understood by the claimant of (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (iv) a statement indicating the claimant's right to file a lawsuit upon completion of the claims procedure process.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will

be provided to the claimant free of charge, or the claimant will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Claims Administrator will provide to the claimant either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

9.06 **Appeal to the Plan Administrator.** If the Claim Administrator denies all or any portion of a claim on appeal, a claimant or his or her duly authorized representative may request a review of such denial by the Plan Administrator, by sending a written request for review to the Plan Administrator within 45 days of the claimant's receipt of the Claim Administrator's claim denial notification.

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

A claimant's written appeal should state why he or she thinks the claim should not have been denied. The appeal should also include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the appeal to the Claim Administrator. The review will not afford deference to the Claim Administrator's decision.

In deciding any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The Plan Administrator will notify a claimant of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of a claimant's request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

9.07 **If the Plan Administrator Denies the Claim on Appeal.** If the Plan Administrator denies a claim on appeal, it will notify the claimant in a manner calculated to be understood by the claimant of (i) the specific reason or reasons for the adverse determination; (ii) reference to the

specific Plan provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (iv) a statement indicating the claimant's right to file a lawsuit upon completion of the claims procedure process.

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

If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Plan Administrator will provide to the claimant either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

9.08 **Legal Actions**. No legal action may be brought against the Plan until the claimant has exhausted all claims and appeals to the Claims Administrator and the Plan Administrator. No such action may be brought after three years from the time a claim should have been filed.

9.09 **Physical Examinations**. The Company has the right, at its own expense, to have any person for whom a claim is pending examined as often as is reasonably necessary.

9.10 **Construction of Article**. This Article IX shall be construed in a manner consistent with Department of Labor Regulations governing claims procedures applicable to disability benefit plans.

ARTICLE X
TERMINATION OF PARTICIPATION

10.01 **Cessation of Participation**. Except as otherwise provided in this Article X, a Participant shall cease to participate in the Plan on the earliest of the following dates:

(i) The date as of which the Plan is terminated;

(ii) The date that the Plan is amended to terminate coverage with respect to a Participant;

(iii) The date a Participant is no longer eligible for coverage under Article III, including without limitation as a result of the Participant's employer no longer being a Related Employer;

(iv) The date a Participant commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994;

(v) The last date for which any required Participant contribution was made;

(vi) The date on which a leave of absence begins; and

(vii) The date a Participant terminates employment.

10.02 Severance. Eligibility for Plan coverage shall continue for an Employee to the extent provided under any severance arrangement between such Employee and the Company. The level of contribution and the conditions of such continuation coverage shall be determined by the terms of the applicable severance agreement.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.01 Assignment of Benefits. No benefit payable at any time under the Plan shall be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, bankruptcy, or, in any other manner, and no benefit payable under the Plan shall be liable for, or subject to, any obligation or liability of any Participant. If any Participant entitled to a benefit under the Plan attempts to alienate, sell, transfer, assign, pledge or otherwise impede a benefit or any part thereof, or if by reason of his or her bankruptcy or other event happening at any time, a benefit devolves upon anyone else or would not be enjoyed by him or her, then the Plan Administrator in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate his or her interest in any such benefit and hold or apply it to or for his or her benefit or the benefit of his or her spouse or dependents, in a manner the Plan Administrator deems proper.

11.02 Information to Be Furnished. Participants shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant any legal or equitable right against the Company, except as provided herein.

11.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

11.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

11.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, the Company shall not be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

11.07 Misrepresentation. Any material misrepresentation on the part of any Participant in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void.

11.08 Inadvertent Error. Inadvertent error by the Plan Administrator in the keeping of records or the transmission of any Enrollment Form shall not deprive any Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within 90 days after it was made.

11.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the Company's rights to discipline or terminate an Employee.

11.10 Participant Responsibilities. Each Participant is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate a Participant. If a Participant becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect, (2) the Participant does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

11.11 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization.

11.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 11.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

11.13 Severability. In the event any portion of the Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of the Plan, and the balance of the Plan shall remain in full force and effect.

11.14 Participant Litigation. In any action or proceeding involving the Plan, Participants or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company or other organization or institution providing benefits

under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Participant or other person concerned. To the extent permitted by applicable law, an election to become a Participant under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

11.15 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

11.16 Notice. Any notice given under the Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Claims Administrator, when addressed to it at its office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Claims Administrator.

11.17 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XII
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

12.01 Plan Self Insured. The Plan is a self-insured plan. All contributions made to the Plan are used to pay claims and related expenses thereunder.

12.02 Participants' and Dependents' Rights Unsecured. The right of a Participant or any other person to receive a distribution hereunder, shall be an unsecured claim against the general assets of the Company and no Participant or any other person shall have any rights in any amount allocated for his or her benefit under the terms of the Plan, or any other specific assets of the Company. All amounts allocated pursuant to the terms of the Plan shall constitute general assets of the Company and may be disposed of by the Company at such time and for such purpose as it may deem appropriate. Benefits payable pursuant to the terms of the Plan shall be paid solely as required out of the general assets of the Company or from any other funding vehicle as may be established by the Company.

12.03 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Any amendment or restatement of the Plan shall not affect existing delegations to amend the Plan. Any such

amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration. To the extent that any applicable collective bargaining agreement imposes a more restrictive requirement regarding Plan eligibility or benefits than is set forth herein, such requirement, as applied solely to those Employees subject to the collective bargaining agreement, is incorporated herein by this reference.

12.04 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

12.05 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article XII, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 16th day of January, 2017, to be effective as of January 1, 2017.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

NISOURCE LIFE INSURANCE PLAN

As Amended and Restated
Effective as of January 1, 2015

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1
1.01 Purpose of Plan 1

ARTICLE II DEFINITIONS 1
2.01 Annual Enrollment Period 1
2.02 Applicable Group Insurance Certificate 1
2.03 Applicable SPD 1
2.04 Code 1
2.05 Committee 1
2.06 Company 1
2.07 Covered Person 1
2.08 Covered Person Contribution 1
2.09 Dependent 2
2.10 Employee 2
2.11 Employer 2
2.12 ERISA 2
2.13 Insurer 2
2.14 Participant 2
2.15 Plan 2
2.16 Plan Administrator 2
2.17 Plan Year 2
2.18 Related Employer 2
2.19 Represented 3
2.20 Retiree 3
2.21 Status Change 3
2.22 Years of Service 3
2.23 Construction 3

ARTICLE III PARTICIPATION 3
3.01 Eligibility 3
3.02 Enrollment 3

ARTICLE IV CONTRIBUTIONS TO THE PLAN 4
4.01 Covered Person Contributions 4
4.02 Employer Contributions 4

ARTICLE V COVERAGE OPTIONS AND BENEFITS 5
5.01 Coverage Options 5
5.02 Payment of Benefits 5
5.03 Designation of Beneficiaries 5

ARTICLE VI GENERAL EXCLUSIONS 5

ARTICLE VII SUBROGATION 5

ARTICLE VIII ADMINISTRATION OF PLAN 5
8.01 Committee and Insurer to Administer the Plan 5
8.02 The Committee 5

8.03 Powers of the Plan Administrator 5
8.04 Interpretative Authority 6

ARTICLE IX CLAIMS FOR BENEFITS 6

ARTICLE X TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE 6
10.01 Cessation of Participation 6
10.02 Severance 9

ARTICLE XI MISCELLANEOUS PROVISIONS 9
11.01 Assignment of Benefits 9
11.02 Information to Be Furnished 9
11.03 Limitation of Rights 9
11.04 Plan Not Contract 9
11.05 Fiduciary Operation 9
11.06 No Guaranty 9
11.07 Misrepresentation 10
11.08 Inadvertent Error 10
11.09 No Limitation of Management Rights 10
11.10 Covered Person's Responsibilities 10
11.11 Right of Recovery 10
11.12 Governing Law and Venue 10
11.13 Severability 10
11.14 Participant Litigation 10
11.15 Counterparts 11
11.16 Notice 11
11.17 Extension of Plan to Related Employers 11

ARTICLE XII FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 11
12.01 Fully Insured Plan 11
12.02 Amendment 11
12.03 Termination 11
12.04 Collective Bargaining Agreement 12

ARTICLE XIII SPECIAL PROVISIONS APPLICABLE TO CERTAIN OUTSOURCED AND SEVERED EMPLOYEES 12
13.01 In General 12
13.02 Age and Service Criteria 12
13.03 Years of Service Defined 12
13.04 Nature of Coverage 12

ARTICLE I
INTRODUCTION

1.01 Purpose of Plan. Columbia Energy Group established and maintained the Columbia Energy Group Life Insurance Benefit Plan to provide group life insurance benefits for the participants and beneficiaries thereunder. Effective as of January 1, 2004, the Columbia Energy Group Life Insurance Benefit Plan was amended and restated, was broadened to include coverage for the former participants and beneficiaries of life insurance plans sponsored by NiSource Inc. (the "Company") or an affiliate, was renamed the NiSource Life Insurance Plan, and as of such date and continuing thereafter, was sponsored and maintained by the Company. The Plan was further amended and restated effective as of January 1, 2008, at which time it became a component welfare plan of the NiSource Life and Medical Benefits Program, and was amended and restated again effective as of January 1, 2010, as of January 1, 2013 and as of January 1, 2014. This is an amendment and restatement of the Plan, effective as of January 1, 2015.

ARTICLE II
DEFINITIONS

2.01 Annual Enrollment Period. "Annual Enrollment Period" means the period selected by the Company each year during which time an Employee may select coverage to be effective for the following Plan Year.

2.02 Applicable Group Insurance Certificate. "Applicable Group Insurance Certificate" means the group insurance certificate issued by the Insurer that is applicable to the group of Employees, Retirees or Dependents to which a Covered Person belongs. Each Applicable Group Insurance Certificate is subject in every way to the group insurance contract or contracts issued by the Insurer that fund Plan benefits, which contract or contracts include the Applicable Group Insurance Certificate.

2.03 Applicable SPD. "Applicable SPD" means the summary plan description applicable to the group of Employees, Retirees or Dependents to which a Covered Person belongs. Each Applicable SPD shall be consistent with the group contract or contracts issued by the Insurer that fund Plan benefits and with the Applicable Group Insurance Certificate. To the extent that an Applicable SPD is inconsistent with the group insurance contract or contracts or with the Applicable Group Insurance Certificate, the terms of the group insurance contract or contracts and the Applicable Group Insurance Certificate shall control.

2.04 Code. "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.05 Committee "Committee" means the NiSource Benefits Committee or its predecessor, the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

2.06 Company. "Company" means NiSource Inc., a Delaware corporation.

2.07 Covered Person. "Covered Person" means an Employee, Retiree or Dependent covered under the Plan.

2.08 Covered Person Contribution. "Covered Person Contribution" means the contribution required under Section 4.01.

2.09 **Dependent**. "Dependent" means a dependent eligible for coverage under the Applicable Group Insurance Certificate.

2.10 **Employee**. "Employee" means an employee of an Employer, provided such employee is eligible for coverage under the Applicable Group Insurance Certificate. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.11 **Employer**. "Employer" means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that an employee welfare benefit plan providing life insurance benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.11, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

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

2.13 **Insurer**. "Insurer" means the insurance carrier selected by the Plan Administrator or the Plan to issue the group insurance contract or contracts that fund Plan benefits.

2.14 **Participant**. "Participant" means each Employee and Retiree who is a Covered Person.

2.15 **Plan**. "Plan" means the NiSource Life Insurance Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.17 **Plan Year**. "Plan Year" means the calendar year.

2.18 **Related Employer**. "Related Employer" means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.19 Represented. "Represented" means an Employee who is covered by a collective bargaining agreement between an Employer and a union.

2.20 Retiree. "Retiree" means a former Employee of an Employer, provided such former Employee is a retiree eligible for coverage pursuant to the Applicable Group Insurance Certificate. Unless provided otherwise in the Applicable Group Insurance Certificate, a 'Retiree' means a former Employee who retired from service with an Employer, in accordance with a plan or procedure adopted by the Employer, after having attained the age of 55 years and ten Years of Service (or, subject to the terms of the Applicable Group Insurance Certificate, after having attained such other age or Years of Service as set forth in the Applicable SPD for the class of former Employees to which such former Employee belongs), provided such Employee belongs to a class of former Employees for whom retiree life insurance benefits are provided, as evidenced by the Applicable SPD for such class of former Employees. Notwithstanding the foregoing, 'Retiree' shall also mean any former Employee who qualifies as a Retiree under the Special Provisions Applicable to Certain Outsourced and Severed Employees described in Article XIII.

2.21 Status Change. "Status Change" shall have the meaning given such term (or any similar term) in the Applicable Group Insurance Certificate.

2.22 Years of Service. "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 the Company or an affiliate in which the Retiree accrued a benefit, as calculated under the terms of each applicable defined benefit pension plan.

2.23 Construction. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

ARTICLE III
PARTICIPATION

3.01 Eligibility.

(a) Employees. Each Employee of an Employer may be covered under the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate.

(b) Dependents. A Dependent of a Participant may be covered by the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate.

(c) Retirees. A Retiree may be covered under the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate. The Company reserves the right to amend or terminate the provisions for Retiree participation in the Plan in accordance with Article XII.

3.02 Enrollment.

(a) New Hires. With respect to a coverage option, such as basic life and accidental death and dismemberment coverage, for which an Employee does not any make contributions to the cost of coverage ("noncontributory coverage"), each Employee who becomes eligible under the Plan shall automatically be enrolled for coverage in accordance with the terms of the Applicable Group Insurance Certificate. With respect to a coverage option for which an Employee must make contributions to the cost of coverage ("contributory

coverage"), as a condition of participation in such coverage option under the Plan, each Employee who becomes eligible for such coverage shall properly enroll on or before the 31st day after the Employee first becomes eligible. Subject to the terms of the Applicable Group Insurance Certificate, such enrollment shall be effective for the period beginning on the first day of eligibility and ending on the last day of the Plan Year in which such participation begins.

(b) Retirees. Each Retiree who becomes eligible to become covered under the Plan shall properly enroll no later than the date of such Retiree's retirement. Such Retiree enrollment shall be effective on the later of the date of the Retiree's retirement or the effective date of coverage set forth in the Applicable Group Insurance Certificate A Retiree who fails to enroll pursuant to this subsection shall be eligible for coverage in accordance with the Applicable Group Insurance Certificate.

(c) Annual Enrollment Period. An Employee eligible for coverage under the Plan may elect or change any coverage option by properly enrolling during the Annual Enrollment Period. Such election shall be effective for the period beginning on the first day of the following Plan Year and ending on the last day of such following Plan Year; provided, however, if such Employee or Retiree makes no election or change during the Annual Enrollment Period, such Employee shall be deemed to have elected to continue his or her existing coverage option for the following Plan Year.

(d) Status Change Enrollment. With respect to any contributory coverage, if a Status Change occurs, an Employee or Retiree eligible for coverage may change his or her enrollment during the Status Change Enrollment Period provided under this subsection; provided, however, if required by Section 125 of the Code and the regulations, rulings and releases issued thereunder, such change in coverage shall be consistent with the Status Change event. Such Status Change Enrollment Period shall begin on the date of the Status Change event, and shall expire 31 days thereafter. Accordingly, to obtain or modify coverage under this subsection, the eligible Employee or Retiree shall properly modify his or her enrollment during such Status Change Enrollment Period. Coverage under this subsection shall be effective as of the date an enrollment change is approved by the Insurer and the Plan Administrator. Any change in enrollment as a result of a Status Change event shall be subject to any applicable requirements or limitations imposed by Section 125 of the Code and the regulations, rulings and releases issued thereunder, and to any additional requirements set forth in the Applicable Group Insurance Certificate.

(e) Evidence of Insurability. To the extent required by the Insurer, Participants and Dependents shall submit evidence of insurability. The Insurer shall have the right to approve or deny any coverage in its sole discretion as a result of such submission or refusal to submit.

ARTICLE IV
CONTRIBUTIONS TO THE PLAN

4.01 Covered Person Contributions. As a condition of participation, a Covered Person shall contribute to the cost of coverage in such amount as may be determined from time to time by the Company.

4.02 Employer Contributions. The Employer will contribute to the cost of the Plan to the extent such cost exceeds the amount contributed by the Covered Person.

ARTICLE V
COVERAGE OPTIONS AND BENEFITS

5.01 **Coverage Options**. Plan coverage options shall be set forth in the Applicable Group Insurance Certificate. Benefits under the Plan shall be determined and paid pursuant to the Applicable Group Insurance Certificate.

5.02 **Payment of Benefits**. All benefits shall be paid directly to the beneficiary of the Covered Person or to the Covered Person, as determined by the Applicable Group Insurance Certificate. Benefits shall be paid by the Insurer.

5.03 **Designation of Beneficiaries**. Each Covered Person from time to time may name a beneficiary under the Plan in accordance with procedures established by the Insurer. All determinations of the identity of any beneficiary shall be made by the Insurer. If a Covered Person fails to designate a beneficiary before his or her death or if the designated beneficiary dies before the date of the Covered Person's death or before complete payment of the Covered Person's benefits, Plan benefits shall be payable in accordance with procedures established by the Insurer.

ARTICLE VI
GENERAL EXCLUSIONS

The Plan shall not provide coverage for any exclusions set forth in the Applicable Group Insurance Certificate.

ARTICLE VII
SUBROGATION

All Covered Persons shall be subject to any subrogation and any third-party recovery provisions as may be established by the Insurer.

ARTICLE VIII
ADMINISTRATION OF PLAN

8.01 **Committee and Insurer to Administer the Plan**. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of ERISA. The Plan Administrator may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA. The Insurer shall be the Plan fiduciary responsible for all claims decisions, including appeals of denied claims.

8.02 **The Committee**. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

8.03 **Powers of the Plan Administrator**. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Covered Persons;

(d) To direct the Insurer to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine the status and rights of all Covered Persons;

(h) To make regulations and prescribe procedures;

(i) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Plan;

(j) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(k) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(l) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

8.04 Interpretative Authority. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any persons or entities in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Applicable Group Insurance Certificates and the Applicable SPDs. Any writing, decision or other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Insurer decides in its discretion that the applicant is entitled to them, in accordance with the provisions of the Plan and the Applicable Group Insurance Certificates.

ARTICLE IX
CLAIMS FOR BENEFITS

All claims for benefits and appeals of denied claims shall be decided by the Insurer in accordance with the procedures contained in the Applicable SPD.

ARTICLE X
TERMINATION OF PARTICIPATION AND CONTINUATION COVERAGE

10.01 Cessation of Participation. Except as otherwise provided in this Article:

(a) An Employee shall cease to participate in the Plan on the earliest of the following dates:

(i) The date as of which the Plan is terminated;

(ii) The date the group insurance contract or contracts that fund Plan benefits are canceled, or with respect to a particular coverage option, the date a coverage option is terminated;

(iii) The date that the Plan is amended to terminate coverage with respect to an Employee;

(iv) The date the Employee's class is no longer covered under the Applicable Group Insurance Certificate, including without limitation as a result of the Employee's employer no longer being a Related Employer;

(v) The last day of the month in which an Employee terminates employment or is otherwise no longer eligible for coverage under the Plan as a member of an eligible class (provided, however, that for purposes of coverage under the Plan, an Employee's eligibility will not cease while the Employee is absent from work due to sickness, injury, leave of absence or temporary layoff, subject to the terms of the Applicable Group Insurance Certificate and the Employer's personnel policies and procedures);

(vi) The end of the month following the date an Employee is no longer eligible for coverage under Section 3.01;

(vii) Thirty-one days after the due date for any required Covered Person Contribution that is not paid, provided that failure to make any required Covered Person Contribution in respect of coverage for a Dependent will not cause Employee coverage to end; and

(viii) The date provided for coverage termination in the Applicable Group Insurance Certificate.

If the Employer under its personnel policies continues to treat an individual as an Employee after the Employee ceases to be actively employed due to the individual's purported disability or other approved leave status, then the Employee will continue to be treated as an Employee eligible to participate in the Plan, subject to the terms, conditions and limitations of the Plan, the group contract or contracts issued by the Insurer that fund Plan benefits, and the Applicable Group Insurance Certificate. Provided, however, that such participation shall cease upon the earliest of any event set forth above. For example, if an Employer terminates an Employee from employment because the claims fiduciary of the Employer's long-term disability plan has determined that the individual no longer qualifies for benefits under the long-term-disability plan, then participation under this Plan shall cease due to such termination from employment.

(b) A Retiree shall cease to participate in the Plan on the earliest of the following dates:

(i) The date as of which the Plan is terminated;

(ii) The date the group insurance contract or contracts that fund Plan benefits are canceled, or with respect to a particular coverage option, the date a coverage option is terminated;

(iii) The date the Plan is amended to terminate coverage with respect to a Retiree;

(iv) The date the Retiree's class is no longer covered under the Applicable Group Insurance Certificate;

(v) The date that a Retiree is no longer eligible for coverage under the Plan as a member of an eligible class, including without limitation as a result of the Retiree's former employer no longer being a Related Employer, unless the Plan Administrator determines, in its discretion, that such event shall not cause a loss of coverage;

(vi) The end of the month following the date a Retiree is no longer eligible for coverage under Section 3.01;

(vii) Thirty-one days after the due date for any required Covered Person Contribution that is not paid;

(viii) The date Retiree coverage ceases pursuant to any Plan amendment; or

(ix) The date provided for coverage termination in the Applicable Group Insurance Certificate.

(c) A Dependent shall cease to be covered under the Plan on the earliest of the following dates:

(i) The date as of which the Plan is terminated;

(ii) The date the group insurance contract or contracts that fund Plan benefits are canceled, or with respect to a particular coverage option, the date a coverage option is terminated;

(iii) The date that the Plan is amended to terminate coverage with respect to a Dependent;

(iv) Thirty-one days after the due date for any required Covered Person Contribution for Dependent coverage that is not paid;

(v) The last day for which premium contributions have been made following the Insurer's receipt of a Participant's written request that coverage for a Dependent end;

(vi) With respect to term life coverage of a Dependent of a Participant, the date that the Participant's term life coverage ends;

(vii) With respect to accident coverage of a Dependent of a Participant, the date that the Participant's optional accident coverage ends;

(viii) The end of the month following the date a Dependent no longer qualifies as a Dependent; or

(ix) The date provided for coverage termination in the Applicable Group Insurance Certificate.

Notwithstanding the provisions of this subsection (c), coverage of a Dependent of a Participant who is an Employee will not end on the date the age limit in the definition of Dependent is reached if the child is then mentally or physically incapable of self-support and the conditions set forth in the Applicable Group Insurance Certificate for continued coverage of such child are satisfied.

10.02 Severance. Eligibility for Plan coverage shall continue for an Employee to the extent provided under any severance arrangement between such Employee and an Employer. The level of contribution and the conditions of such continuation coverage shall be determined by the terms of the applicable severance agreement and are subject to approval for continuation coverage by the Insurer.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.01 Assignment of Benefits. A Covered Person may assign benefits to the extent permitted by the Insurer.

11.02 Information to Be Furnished. Covered Persons shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.03 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person any legal or equitable right against the Company or any Employer, except as provided herein.

11.04 Plan Not Contract. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company or an Employer with the bargaining representative of any Employee.

11.05 Fiduciary Operation. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

11.06 No Guaranty. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only by the Insurer.

11.07 Misrepresentation. Any material misrepresentation on the part of any Covered Person in making application for coverage, or any application for reclassification thereof, shall render the coverage null and void.

11.08 Inadvertent Error. Subject to the terms of the Applicable Group Insurance Certificate, inadvertent error by the Plan Administrator in the keeping of records or the transmission of any enrollment shall not deprive any Participant or Dependent of benefits otherwise due, if such inadvertent error is corrected by the Plan Administrator within ninety (90) days after it was made.

11.09 No Limitation of Management Rights. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the rights of the Company or any Employer to discipline or terminate an Employee.

11.10 Covered Person's Responsibilities. Each Covered Person is responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect, (2) the Covered Person does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

11.11 Right of Recovery. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Plan shall have the right to recover such payments, to the extent of such excess.

11.12 Governing Law and Venue. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Covered Persons under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 11.12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Covered Person, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

11.13 Severability. In the event any portion of this Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of this Plan, and the balance of the Plan shall remain in full force and effect.

11.14 Participant Litigation. In any action or proceeding involving the Plan, Covered Persons or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against any Employer, the Plan or other organization or institution providing benefits under the Plan by or on behalf of any person, and such action results

adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Employer, the Plan or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Covered Person or other person concerned. To the extent permitted by applicable law, an election to become a Covered Person under the Plan shall constitute a release of the Company and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

11.15 Counterparts. This Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

11.16 Notice. Any notice given under this Plan shall be sufficient, if given to the Plan Administrator, when addressed to it at its principal office; if given to the Insurer, when addressed to it at its home office; or if given to a Participant, when addressed to the Participant at his or her address as it appears on the records of the Plan Administrator.

11.17 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees and Retirees to become Participants hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE XII
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

12.01 Fully Insured Plan. The Plan is a fully-insured plan. All contributions related to the Plan are used to pay insurance premiums and related expenses thereunder.

12.02 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Unless expressly provided, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect.

12.03 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

12.04 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

ARTICLE XIII
SPECIAL PROVISIONS APPLICABLE TO CERTAIN OUTSOURCED AND SEVERED EMPLOYEES

13.01 In General. Notwithstanding any provision of the Plan to the contrary, any Participant who (i) was notified in writing on June 21, 2005, or any following date up to and including December 31, 2005, that his or her employment was outsourced to International Business Machines Corporation (the "IBM Outsourcing"), or (ii) received an initial Severance Letter Agreement dated on June 21, 2005, or any following date up to and including December 31, 2005, from the Company in connection with the IBM Outsourcing, shall be considered a Retiree and eligible for retiree life insurance coverage under the Plan as described in this Article.

13.02 Age and Service Criteria.

(a) Each Participant who is age 50 to 54 with at least 10 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree upon reaching age 55;

(b) Each Participant who is age 55 or over with 5 to 9 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree as of the date that such individual would have completed 10 Years of Service had he or she continued to be employed by the Company or a Related Employer but for the IBM Outsourcing or related severance;

(c) Each Participant who is age 50 or over with 5 to 9 Years of Service as of his or her termination of employment with the Company and any Related Employer shall be considered a Retiree as of the date that such individual reaches age 55 and would have completed 10 Years of Service had he or she continued to be employed by the Company or a Related Employer but for the IBM Outsourcing or related severance.

13.03 Years of Service Defined. For purposes of this Article, "Years of Service" equals the number of Years of Service earned by a former Employee towards eligibility for an early retirement pension under each defined benefit pension plan maintained by the Company or an affiliate in which the former Employee participated, as calculated under the terms of each applicable defined benefit pension plan; provided, however, that Years of Service shall not include any pension service time added as a result of the IBM Outsourcing or severance in connection with the IBM Outsourcing.

13.04 Nature of Coverage. Each individual who is considered a Retiree under this Article shall be eligible for the Retiree life insurance coverage under the Plan that he or she would have received if he or she retired on the date that he or she became a Retiree under this Article.

[Signature page follows.]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 22nd day of June, 2015, to be effective as of January 1, 2015.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

FIRST AMENDMENT TO THE NISOURCE LIFE INSURANCE PLAN

(As Amended and Restated Effective January 1, 2015)

WHEREAS, NiSource Inc. (the "Company") maintains the NiSource Life Insurance Plan, as amended and restated effective January 1, 2015 (the "Plan"); and

WHEREAS, pursuant to Section 12.02 of the Plan, and subject to Section 12.04 thereof, the NiSource Benefits Committee (the "Committee") has reserved the right to amend the Plan; and

WHEREAS, pursuant to resolutions adopted by the Committee, the Committee desires to amend the Plan, effective as of June 1, 2016, to modify the eligibility provisions and the definition of "Employer" to clarify the status, during the period from June 1, 2016, to April 30, 2019, of specified participants in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and the Northern Indiana Public Service Company with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019.

NOW, THEREFORE, the Plan is hereby amended, effective as June 1, 2016, as follows:

1. Section 2.11, **"Employer,"** of the Plan is hereby amended to recite in its entirety as follows:

> **2.11 "Employer"** "Employer" means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that an employee welfare benefit plan providing life insurance benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.11, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014. For the avoidance of doubt, the term "Employer" includes Northern Indiana Public Service Company ("NIPSCO") with respect to an employee employed by NIPSCO in the role of Damage Prevention Coordinator with an assigned job

code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) (hereinafter, "Damage Prevention Coordinator") during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and NIPSCO with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019, unless such employee was considered an employee covered by a collective bargaining agreement between NIPSCO and a union immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator.

2. Section 3.01, "**Eligibility,**" of the Plan is hereby amended to recite in its entirety as follows:

3.01 Eligibility.

(a) Employees. Each Employee of an Employer may be covered under the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate. For the avoidance of doubt, no person may be covered under the Plan during such period that he or she is eligible for coverage under the Northern Indiana Public Service Company Employee Life Insurance Plan.

(b) Dependents. A Dependent of a Participant may be covered by the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate.

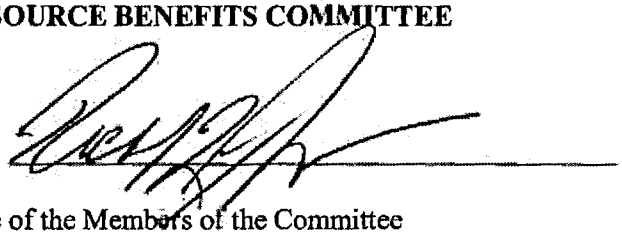
(c) Retirees. A Retiree may be covered under the Plan solely in accordance with the terms of the Applicable Group Insurance Certificate. The Company reserves the right to amend or terminate the provisions for Retiree participation in the Plan in accordance with Article XII.

3. All other provisions of the Plan shall remain unchanged.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this First Amendment to the NiSource Life Insurance Plan to be executed on its behalf by one of its members duly authorized, effective as of June 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: 

One of the Members of the Committee

NISOURCE INC. RETIREMENT SAVINGS PLAN

Amended and Restated Effective as of January 1, 2014

December 2014

TABLE OF CONTENTS

Page

ARTICLE I DEFINITIONS 3
Section 1.01 AB I Benefit 3
Section 1.02 AB II Benefit 3
Section 1.03 Account (or Account Balance) 3
Section 1.04 After-tax Contribution Account 3
Section 1.05 Bay State 3
Section 1.06 Bay State Pension Plan 3
Section 1.07 Bay State Union 401(k) Plan 3
Section 1.08 Bay State Union Employee 3
Section 1.09 Bay State Union Plan 3
Section 1.10 Beneficiary 3
Section 1.11 Catch-up Contribution Account 4
Section 1.12 Code 4
Section 1.13 Columbia 4
Section 1.14 Columbia Pension Plan 4
Section 1.15 Columbia Union Employee 4
Section 1.16 Committee 4
Section 1.17 Company 4
Section 1.18 Company Stock 4
Section 1.19 Company Stock Fund 4
Section 1.20 Compensation 4
Section 1.21 Disability 8
Section 1.22 Effective Date 8
Section 1.23 Eligible Employee 8
Section 1.24 Employee 9
Section 1.25 Employer(s) 9
Section 1.26 Employment Commencement Date 9
Section 1.27 ERISA 9
Section 1.28 FAP Benefit 10
Section 1.29 Former Participant 10
Section 1.30 Highly Compensated Employee 10
Section 1.31 Income 10
Section 1.32 Investment Manager 10
Section 1.33 Kokomo 11
Section 1.34 Kokomo Pension Plan 11
Section 1.35 Kokomo Union Employee 11
Section 1.36 Leased Employee 11
Section 1.37 Matching Account 11
Section 1.38 Next Gen Employee 11
Section 1.39 Next Gen Employer Contribution Account 12
Section 1.40 NIFL 12
Section 1.41 NIFL Union Employee 12
Section 1.42 NIPSCO 12
Section 1.43 NIPSCO 401(k) Plan 13

TABLE OF CONTENTS

Page

Section 1.44 NIPSCO Union Employee 13
Section 1.45 NIPSCO Union Pension Plan 13
Section 1.46 NiSource Pension Plans 13
Section 1.47 NiSource Salaried Pension Plan 13
Section 1.48 Non-highly Compensated Employee 13
Section 1.49 Participant 14
Section 1.50 Period of Service 14
Section 1.51 Plan 14
Section 1.52 Plan 2006 Restatement 14
Section 1.53 Plan Administrator 14
Section 1.54 Plan Sponsor 14
Section 1.55 Plan Year 14
Section 1.56 Pre-tax Contribution Account 14
Section 1.57 Profit Sharing Account 14
Section 1.58 Reemployment Commencement Date 14
Section 1.59 Related Employers 14
Section 1.60 Required Beginning Date 15
Section 1.61 Rollover Account 15
Section 1.62 Roth Contribution Account 15
Section 1.63 Service 15
Section 1.64 Severance from Employment 15
Section 1.65 Spouse 15
Section 1.66 Subsidiary Pension Plan 15
Section 1.67 Transfer Account 15
Section 1.68 Treasury Regulations 15
Section 1.69 Trust 16
Section 1.70 Trust Agreement 16
Section 1.71 Trust Fund 16
Section 1.72 Trustee(s) 16
Section 1.73 Valuation Date 16
Section 1.74 Terms Defined Elsewhere 16

ARTICLE II ELIGIBILITY AND PARTICIPATION 18
Section 2.01 Eligibility 18
Section 2.02 Participation Upon Re-Employment 19
Section 2.03 Transfers Between Employers 19
Section 2.04 Changes in Participant's Job Classification 20
Section 2.05 Termination Of Participation 20

ARTICLE III CONTRIBUTIONS 21
Section 3.01 Individual Accounts 21
Section 3.02 Participant Contributions 21
Section 3.03 Elections, Changes and Suspensions of Participant Contributions 23
Section 3.04 Matching Contributions 23

TABLE OF CONTENTS

Page

Section 3.05 Matching Contribution Allocation and Accrual of Benefit 23
Section 3.06 Profit Sharing Contributions and Next Gen Employer Contributions 23
Section 3.07 Profit Sharing and Next Gen Employer Contribution Allocation / Investment 25
Section 3.08 Time and Form of Payment of Contribution 25
Section 3.09 Rollover and Transfer Contributions 26
Section 3.10 Return of Contributions 26

ARTICLE IV VESTING; TIME AND METHOD OF PAYMENT OF BENEFITS 27
Section 4.01 Vested Benefit 27
Section 4.02 Distribution Upon Severance From Employment, Disability or Death 27
Section 4.03 Payment Timing 27
Section 4.04 Form of Benefit Payment 29
Section 4.05 Distributions Upon Death 29
Section 4.06 Revised Required Minimum Distributions 29
Section 4.07 Designation of Beneficiary 34
Section 4.08 Failure of Beneficiary Designation 35
Section 4.09 Special Rules for Transfer Accounts 35
Section 4.10 Distributions Under Domestic Relations Orders 35
Section 4.11 Lost Participant or Beneficiary 36
Section 4.12 Facility of Payment 37
Section 4.13 No Distribution Prior to Severance From Employment, Death or Disability 37
Section 4.14 Written Instruction Not Required 38

ARTICLE V WITHDRAWALS; DIRECT ROLLOVERS AND WITHHOLDING; LOANS 39
Section 5.01 General Rules 39
Section 5.02 Withdrawals of After-tax and Rollover Contributions 39
Section 5.03 Withdrawals of Matching Contributions and Profit Sharing Contributions 39
Section 5.04 Withdrawals at Age 59½ 40
Section 5.05 Hardship Withdrawals 40
Section 5.06 Withdrawals During Military Service 42
Section 5.07 Direct Rollover and Withholding Rules 42
Section 5.08 Loans to Participants 45
Section 5.09 Special Withdrawal Rules Applicable to Transfer Accounts 48

ARTICLE VI TESTING OF PRE-TAX, AFTER-TAX AND MATCHING CONTRIBUTIONS 49
Section 6.01 Definitions 49
Section 6.02 Pre-tax and Roth Contributions: 401(k) Tests 49

TABLE OF CONTENTS

Page

Section 6.03 Correction of Excess Contributions 51
Section 6.04 After–tax and Matching Contributions: 401(m) Tests 53
Section 6.05 Correction of Excess Aggregate Contributions 54
Section 6.06 Alternative to Distribution of Excess Amounts 56

ARTICLE VII LIMITATIONS ON CONTRIBUTIONS AND BENEFITS 57
Section 7.01 Dollar Limitations on Pre–tax Contributions 57
Section 7.02 Annual Additions — Definitions 58
Section 7.03 Limitations Under Code Section 415 59

ARTICLE VIII TRUST CREATION, ALLOCATION AND INVESTMENTS 61
Section 8.01 Establishment of Trust 61
Section 8.02 Accounting and Adjustments 61
Section 8.03 Value of Participant's Account 61
Section 8.04 Investment Funds 61
Section 8.05 Participant Direction of Investment 62
Section 8.06 Administration of Investment Designations 62
Section 8.07 Special Rules Pertaining to Investment of Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions 63
Section 8.08 Special Rules Pertaining to the Company Stock Fund 63

ARTICLE IX PARTICIPANT ADMINISTRATIVE PROVISIONS 67
Section 9.01 Personal Data to Committee 67
Section 9.02 Address For Notification 67
Section 9.03 Assignment or Alienation 67
Section 9.04 Notice of Change in Terms 67
Section 9.05 Litigation Against the Trust 67
Section 9.06 Information Available 67
Section 9.07 Special Rules Relating to Veterans Reemployment Rights Under USERRA 68
Section 9.08 Claims Procedure 69

ARTICLE X ADMINISTRATION OF THE PLAN 71
Section 10.01 Allocation of Responsibility Among Fiduciaries For Plan and Trust Administration 71
Section 10.02 Appointment of Committee 71
Section 10.03 Committee Procedures 71
Section 10.04 Other Committee Powers and Duties 72
Section 10.05 Rules and Decisions 73
Section 10.06 Application and Forms For Benefits 73
Section 10.07 Authorization of Benefit Payments 73
Section 10.08 Funding Policy 73
Section 10.09 Fiduciary Duties 73
Section 10.10 Allocation or Delegation of Duties and Responsibilities 74

TABLE OF CONTENTS

Page

Section 10.11 Procedure For the Allocation or Delegation of Fiduciary Duties 74
Section 10.12 Records and Reports 74
Section 10.13 Individual Statement 74
Section 10.14 Fees and Expenses From Fund 75
Section 10.15 Use of Alternative Media 75
Section 10.16 Information to Plan Administrator 75
Section 10.17 Limitation of Liability 75
Section 10.18 Indemnity 76
Section 10.19 Severability 76
Section 10.20 Recovery of Overpaid Benefits 76
Section 10.21 Forfeitures 76

ARTICLE XI TOP HEAVY RULES 77
Section 11.01 Minimum Employer Contribution 77
Section 11.02 Additional Contribution 77
Section 11.03 Determination of Top Heavy Status 78
Section 11.04 Top Heavy Vesting Schedule 79
Section 11.05 Definitions 79

ARTICLE XII MISCELLANEOUS 81
Section 12.01 Evidence 81
Section 12.02No Responsibility For Employer Action 81
Section 12.03 Fiduciaries Not Insurers 81
Section 12.04 Waiver of Notice 81
Section 12.05 Successors 81
Section 12.06 Word Usage 81
Section 12.07 Headings 81
Section 12.08 State Law 81
Section 12.09 Employment Not Guaranteed 82

ARTICLE XIII PLAN ADOPTION 83
Section 13.01 Adoption Procedure 83
Section 13.02 Joint Employers 83
Section 13.03 Expenses 83
Section 13.04 Withdrawal 83
Section 13.05 Superseded Plans 83

ARTICLE XIV EXCLUSIVE BENEFIT, AMENDMENT, TERMINATION 84
Section 14.01 Exclusive Benefit 84
Section 14.02 Amendment By the Committee 84
Section 14.03 Discontinuance 84
Section 14.04 Full Vesting on Termination 85
Section 14.05 Merger, Direct Transfer and Elective Transfer 85
Section 14.06 Termination 86
Section 14.07 Manner of Distribution 86

TABLE OF CONTENTS

Page

SCHEDULE I I-1
SCHEDULE II II-1
SCHEDULE III III-1

NISOURCE INC. RETIREMENT SAVINGS PLAN

Purpose

NiSource Inc., a Delaware corporation (the "Company"), sponsors the NiSource Inc. Retirement Savings Plan (the "Plan") for the benefit of Eligible Employees of the Company and any other Related Employer that adopts the Plan. The Plan is hereby amended and restated in its entirety, effective as of January 1, 2014, unless otherwise stated herein.

Special effective dates are included with respect to a number of provisions as necessary to conform to various legislation and guidance under the Code and ERISA, including (but not limited to) the following: the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) (with technical corrections made by the Job Creation and Worker Assistance Act of 2002 (JCWAA)); revisions required to comply with Code Section 415 (as such provisions were previously adopted by the Company in a separate Plan amendment); the Pension Protection Act of 2006 (PPA '06); the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART); and the Worker, Retiree, and Employer Recovery Act of 2008 (WRERA). The NiSource Benefits Committee (the "Committee") amended and restated the Plan effective as of January 1, 2009 to reflect various design changes and to update the Plan in accordance with the legislative changes referenced above (the "Plan 2009 Restatement"). The Committee amended and restated the Plan again generally effective January 1, 2009 to make certain clarifications with respect to the administration and operation of the Plan (the "Plan 2010 Restatement") and amended and restated the Plan effective as of January 1, 2012 to reflect the merger of Kokomo Gas and Fuel Company and Northern Indiana Fuel & Light Company, Inc. with and into Northern Indiana Public Service Company, a wholly owned subsidiary of NiSource Inc., as well as to make certain clarifications with respect to the administration and operation of the Plan (the "Plan 2012 Restatement"). The Committee further amended and restated the Plan on two separate occasions, in both cases generally effective as of January 1, 2013, to make various modifications with respect to the administration and operation of the Plan (the "Plan 2013 Restatements"). The Committee now amends and restates the Plan as of the Effective Date to update the Plan as necessary to reflect negotiated benefit changes for various union employee groups participating in the Plan, to update the automatic contribution provisions and to reflect various additional clarifications with respect to the administration and operation of the Plan (the "Plan 2014 Restatement").

The Plan is intended to be qualified under Code Section 401(a), with a cash or deferred arrangement qualified under Code Section 401(k) and its corresponding trust exempt from taxation under Code Section 501(a). In addition, the Plan is intended to be a profit sharing plan pursuant to the requirements of Code Section 401(a)(27). The portion of the Plan related to Accounts invested in the Company Stock Fund, and the dividends thereon, shall constitute an employee stock ownership plan under Code §4975(e)(7).

The provisions of this amended and restated Plan shall apply solely to an Employee whose employment with the Employer terminates on or after the Effective Date, or with respect to the application of a specific Plan provision containing a different effective date, then such provision shall apply to an Employee who terminates on or after such effective date or as

otherwise specified herein. An Employee whose employment with the Employer terminates prior to the Effective Date (or other applicable date with respect to a specific Plan provision containing a different effective date) shall be entitled to a benefit, if any, as determined under the provisions of the Plan or the Prior Plan (the plans as described below in the Plan Background section) in effect on the date that his employment terminated.

Plan Background

The Plan was designated the "NiSource Inc. Retirement Savings Plan" effective January 1, 2002 at the time of a merger of four plans into the Columbia Savings Plan (the "*Columbia 401(k) Plan*") (a plan that was originally effective September 1, 1958 and previously sponsored by Columbia Energy Group ("*Columbia*")). The four plans that merged effective January 1, 2002 into the Columbia 401(k) Plan (renamed the NiSource Inc. Retirement Savings Plan) are as follows: (1) the NiSource Inc. Tax Deferred Savings Plan ("*NiSource 401(k) Plan*") (originally effective May 1, 1984 and formerly known under certain other plan names as described in the Plan 2006 Restatement); (2) the Bay State Gas Company Employee Savings Plan (the "*Bay State 401(k) Plan*") (established effective January 1, 1979 by the Bay State Gas Company ("*Bay State*"); (3) the Kokomo Gas and Fuel Company Bargaining Unit Tax Deferred Savings Plan ("*Kokomo 401(k) Plan*") (established effective April 1, 1995 by Kokomo Gas and Fuel Company ("*Kokomo*")); and (4) the Northern Indiana Fuel & Light Company, Inc. Payroll Savings Plan ("*NIFL 401(k) Plan*") (established effective January 1, 1986 by Northern Indiana Fuel & Light Company, Inc. ("*NIFL*")). Columbia, Bay State, Kokomo, NIFL are wholly owned subsidiaries of NiSource Inc. effective as of the dates described in the Plan 2006 Restatement.

Effective December 31, 2008, two other plans were merged into the Plan: (1) the Bay State Gas Company Savings Plan for Operating Employees (the "*Bay State Union 401(k) Plan*") (originally established effective January 1, 1988); and (2) the Northern Indiana Public Service Company Bargaining Unit Tax Deferred Savings Plan (the "*NIPSCO 401(k) Plan*") (originally established October 1, 1987 by Northern Indiana Public Service Company ("*NIPSCO*")). Effective July 1, 2011, Kokomo and NIFL are merged with and into NIPSCO, a wholly owned subsidiary of NiSource Inc.

ARTICLE I

DEFINITIONS

Each word and phrase defined in this Article I shall have the following meaning whenever such word or phrase is capitalized and used herein unless a different meaning is clearly required by the context of this agreement.

Section 1.01 AB I Benefit. The term used to describe the "Account Balance Option" benefit (renamed the "AB I" benefit) in any of the applicable NiSource Pension Plans that offer such a cash balance benefit as defined therein.

Section 1.02 AB II Benefit. The term used to describe the "Account Balance 2011 Option" benefit (renamed the "AB II" benefit) in any of the applicable NiSource Pension Plans that offer such a cash balance benefit as defined therein.

Section 1.03 Account (or Account Balance). The separate bookkeeping account that the Plan Administrator or the Trustee shall maintain for a Participant pursuant to Section 3.01 of this Plan.

Section 1.04 After-tax Contribution Account. The portion of a Participant's Account credited with After-tax Contributions under Section 3.02C, and adjustments relating thereto.

Section 1.05 Bay State. Bay State Gas Company, or any successor(s).

Section 1.06 Bay State Pension Plan. The Bay State Gas Company Pension Plan, or any successor plan (as defined therein).

Section 1.07 Bay State Union 401(k) Plan. The Bay State Gas Company Savings Plan for Operating Employees, which merged into the Plan effective December 31, 2008.

Section 1.08 Bay State Union Employee. An Eligible Employee of Bay State (or any Related Employer of Bay State), whose compensation, conditions of employment or position are covered by a collective bargaining agreement to which Bay State is a party and which agreement calls for the Employee's participation in the Plan (or prior to December 31, 2008, in the Bay State Union 401(k) Plan).

Section 1.09 Bay State Union Plan. The Bay State Union Pension Plan (f/k/a the Pension Plan For Operating Employees of Bay State Gas Company), or any successor plan (as defined therein).

Section 1.10 Beneficiary. A person, including any individual, legal representative, estate or other entity, designated by a Participant who is or may become entitled to a benefit under the Plan. A Beneficiary who becomes entitled to a benefit under the Plan shall remain a Beneficiary under the Plan until the Trustee has fully distributed his benefit to him. A Beneficiary's right to (and the Plan Administrator's or a Trustee's duty to provide to the

Beneficiary) information or data concerning the Plan shall not arise until he first becomes entitled to receive a benefit under the Plan. A Participant's designation of a Beneficiary shall not change upon divorce or dissolution of marriage unless such Participant designates a new Beneficiary or remarries.

Section 1.11 Catch–up Contribution Account. That portion of a Participant's Accounts credited with Catch–up Contributions under Section 3.02B, and adjustments relating thereto.

Section 1.12 Code. The Internal Revenue Code of 1986, as it may be amended from time to time.

Section 1.13 Columbia. Columbia Energy Group, or any successor(s).

Section 1.14 Columbia Pension Plan. The Columbia Energy Group Pension Plan (f/k/a the Retirement Plan of Columbia Energy Group Companies), or any successor plan (as defined therein).

Section 1.15 Columbia Union Employee. An Eligible Employee of Columbia (or any Related Employer of Columbia), whose compensation, conditions of employment or position are covered by a collective bargaining agreement to which Columbia is a party and which agreement calls for the Employee's participation in the Plan.

Section 1.16 Committee. The NiSource Benefits Committee, established and maintained pursuant to Article X to administer and amend the Plan.

Section 1.17 Company. NiSource Inc., a Delaware corporation, or its successor or successors. The Company is the Plan Sponsor.

Section 1.18 Company Stock. The common stock shares of NiSource Inc., a Delaware corporation.

Section 1.19 Company Stock Fund. The Investment Fund established to facilitate investments by Participants in Company Stock of the Company, as further described in Section 8.08.

Section 1.20 Compensation. Except to the extent modified for specific Participant groups as set forth below, Compensation means the aggregate basic annual salary or wage and commissions paid to a Participant by his Employer. Compensation shall include the following: (1) one-time payments in lieu of salary increases for any Plan Year (referred to as "lump-sum merit pay") (included effective September 1, 2009); (2) amounts deferred and excluded from the Participant's taxable income pursuant to Code Sections 125, 132(f)(4), 402(e)(3), or 402(h)(1)(B); (3) any amounts deferred to a nonqualified plan maintained by an Employer (provided such amounts are only included for purpose of calculating Participant contributions and Matching Contributions described in Sections 3.02 and 3.04 respectively); and (4) solely with respect to Participants subject to the NiSource Vacation Policy ("Vacation Policy") and subject to any payment timing limitations set forth below, any amounts attributable to "banked" vacation (as that term is described in the Vacation Policy) during the calendar year including such Participant's date of termination of employment.

For purposes of the foregoing paragraph, "aggregate basic annual salary or wages" shall exclude various forms of compensation, including (but not limited to) the following: overtime, performance-based pay (such as annual incentive payments or bonuses), supplementary compensation payments, retirement benefits, unused and accrued vacation, and other special forms of compensation such as shift differential, call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

Effective January 1, 2009, for Participants on active duty in the uniformed services for a period of more than 30 days, Compensation shall include any differential wage payments, as defined by Code Section 3401(h)(2), to the extent such payments are made by the Company. Such differential wage payments shall be treated as compensation for all Plan purposes, including Code Section 415 and any other Code section that references the definition of compensation under Code Section 415. A Participant receiving such differential wage payment shall be treated as an Employee of the Employer making the payment. If all employees of the Employer performing service in the uniformed services described in Code Section 3401(h)(2)(A) are entitled to receive differential wage payments on reasonably equivalent terms and, if eligible to participate in a retirement plan maintained by the Employer, to make contributions based on the payments on reasonably equivalent terms (taking into account Code Sections 410(b)(3), (4), and (5)), then the Plan shall not be treated as failing to meet the requirements of any provision described in Code Section 414(u)(1)(C) by reason of any contribution or benefit which is based on the differential wage payment.

Effective for limitations years beginning on or after July 1, 2007, for purposes of applying the limitations of Article VII and to the extent otherwise included in Plan Compensation, Compensation generally shall exclude amounts paid after Severance from Employment. However, Compensation shall include post–severance amounts set forth in items (i) and (ii) below to the extent such amounts are paid by the later of 2 ½ months after Severance from Employment or by the end of the Plan Year (the Limitation Year for purposes of Article VII) that includes the date of such Severance from Employment. Provided the foregoing timing–of–payment condition is met, Compensation shall include:

(i) Regular pay paid after Severance from Employment if: (a) the payment is regular compensation for services during the Participant's regular working hours, or compensation for services outside the Employee's regular working hours (such as overtime or shift differential), commissions, bonuses, or other similar payments; and (b) the payment would have been paid to the Employee prior to a Severance from Employment if the Employee had continued in employment with the Employer; and

(ii) Payments of unused accrued bona fide sick, vacation, or other leave (but only if the Employee would have been able to use the leave if employment had continued).

A. Considerations by Specific Group. Subject to any limitations imposed by Code Section 415 as set forth in this Section, the following additional provisions regarding Compensation shall apply:

(i) In General. The definition of Compensation set forth above shall apply to: (a) Participants eligible for the AB II Benefit (including Bay State Union Employees eligible for the AB II Benefit), (b) Next Gen Employees, and (c) NIPSCO Union Employees who are AB I Participants (subject to the exception in subparagraph (iii) below regarding the determination of Participant Contributions).

(ii) NIPSCO Union Employees who are FAP Participants. For Participants who are NIPSCO Union Employees (including former NIFL Union Employees and former Kokomo Union Employees) who are FAP Participants, the definition of Compensation set forth above shall apply with the following modifications: Compensation shall also include annual incentive payments, overtime, and shift differential.

(iii) NIPSCO Union Employees who are AB I Participants. For Participants who are NIPSCO Union Employees and are eligible for the AB I Benefit, the definition of Compensation set forth above shall not apply for purposes of determining Participant Contributions under Section 3.02: Instead, for the purpose determining such contributions, Compensation shall be the total amount paid to an Employee for personal services that are considered as "wages" on Federal Income Tax Withholding Statement (Form W-2) as adjusted below:

1. Compensation shall be included the extent that any amounts are included as Compensation on Form W-2. In accordance with this, Compensation shall specifically include items such as the following: (1) lump-sum merit pay (as defined earlier in this Section); (2) amounts deferred and excluded from the Participant's taxable income pursuant to Code Sections 125, 132(f)(4), 402(e)(3), or 402(h)(1)(B); (3) commissions (to the extent an Employee is compensated in whole or in part on a commission basis); (4) performance-based pay received by an Employee from an Employer; and (5) overtime payments.

2. Compensation shall be excluded the extent that any amounts are not included as Compensation on Form W-2, except that Compensation shall exclude the following : (1) severance pay; (2) amounts deferred to a nonqualified plan maintained by an Employer; (3) sign-on bonuses, retention premiums, and attendance bonuses and awards; and (4) all other taxable fringe benefits, including stock options and other stock related benefits, relocation expenses and imputed income.

(iv) Bay State Union Employees. For Bay State Union Employees (other than those eligible for the AB II Benefit as noted in subsection A.(i) above), the first sentence of this Section (describing Compensation as "basic annual salary or wage and commissions") shall not apply. Instead, Compensation is straight time wages. The Compensation inclusions set forth above shall continue to apply with the following modifications: Compensation shall also include shift differential, Saturday/Sunday premiums, compensation paid at an alternative rate (not including compensation paid at an alternative rate to a salesperson), and seventy-five percent of sales commissions paid

to an Eligible Employee by an Employer while he is a Participant during the current period.

The Compensation exclusions set forth above shall be disregarded and the following Compensation exclusions shall apply: (1) all daily or weekly overtime; (2) bonuses; (3) supplementary compensation payments; (4) retirement benefits; (5) unused and accrued vacation; and (6) other forms of non-recurring compensation or special forms of compensation including, but not limited to, the following (unless specifically included in this subsection (iv)): call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

B. Compensation – Contributions by the Employer. Subject to any limitations imposed by Code Section 415, and in order to comply with Code Section 401(a)(4), the following additional provisions regarding Compensation shall apply:

(i) Profit Sharing Contributions. For purposes of calculating Profit Sharing Contributions described in Section 3.06A, Compensation for a Plan Year shall be defined as determined under the Annual Incentive Plan of an Employer in effect for such Plan Year, reduced by any amounts deferred to a nonqualified plan maintained by an Employer. In clarification of the foregoing, for purposes of calculating Profit Sharing Contributions, Compensation means base earnings for the calendar year. Compensation shall include (1) all shift premiums (*i.e.*, shift differential, call-out, standby, upgrades, and temporary reclassifications/promotions) and overtime pay for the calendar year; (2) sales commissions to the extent that such commissions are considered part of the Participant's "base earnings"; (3) one-time payments in lieu of salary increases for any Plan Year (referred to as "lump-sum merit pay") (included effective September 1, 2009); and (4) amounts deferred and excluded from the Participant's taxable income pursuant to Code Sections 125, 132(f)(4), 402(e)(3), or 402(h)(1)(B). Compensation shall exclude reimbursements for educational assistance, relocation, meals and mileage, as well as incentive payments, bonuses, stock option gains, long-term disability payments, any amounts deferred to a nonqualified plan maintained by an Employer, supplementary compensation payments, retirement benefits, unused and accrued vacation, sign-on bonuses, retention premiums, payments for waiving certain benefits including health care and dental benefits (referred to as "flex credits"), attendance bonuses and awards, and imputed income.

(ii) Employer Contributions for Next Gen Employees. For purposes of calculating Employer contributions for Next Gen Employees (Next Gen Employer Contributions as described in Section 3.06C), the general definition of Compensation described in this Section shall apply with the following modification: Compensation shall exclude any amounts deferred to a nonqualified plan maintained by an Employer.

C. Compensation Limit. In addition to other applicable limitations set forth in the Plan, and notwithstanding any other provisions of the Plan to the contrary, the annual Compensation of each Employee taken into account under the Plan shall not exceed the

"Compensation Limit." The Compensation Limit for 2014 is $260,000 and for 2015 is $265,000, and is subject to cost of living adjustments in subsequent years in accordance with Code Section 401(a)(17)(B). Any such cost of living adjustment in effect for a calendar year applies to any period, not exceeding 12 months, over which Compensation is determined (the "Determination Period") beginning in such calendar year. If a Determination Period consists of fewer than 12 months, the Compensation Limit will be multiplied by a fraction, the numerator of which is the number of months in the Determination Period, and the denominator of which is 12. Any reference in this Plan to the limitation under Section 401(a)(17) of the Code shall mean the Compensation Limit set forth in this provision.

D. Compensation – Special Rules. For purposes of Article VI ("Testing of Pre-Tax, After-Tax and Matching Contributions"), Article VII ("Limitations on Contributions and Benefits"), and Article XI ("Top Heavy Rules"), the definition of Compensation shall be determined in accordance with Treasury Regulation Section 1.415(c)-2(d)(4) (commonly known as "W-2 Compensation"). For purposes of Articles VI and XI, the Employer may elect to use an alternate nondiscriminatory definition of Compensation, in accordance with the requirements of Code Section 414(s) and the Treasury Regulations promulgated thereunder. In determining Compensation under Articles VI and XI, the Employer may elect to include as Compensation all Elective Contributions (as defined in Code Section 415(c)(3)(D)(i) and (ii)) made by the Employer on behalf of Employees. The Employer's election to include Elective Contributions must be consistent and uniform with respect to Employees and all plans of the Employer for any particular Plan Year. The Employer may make this election to include Elective Contributions irrespective of whether Elective Contributions are included in the general definition of Compensation applicable to the Plan.

Section 1.21 Disability. A physical or mental condition that results in a determination of disability status that entitles the Employee to disability benefits under any group long-term disability plan sponsored by the Employer, as determined under the terms of such plan.

Section 1.22 Effective Date. January 1, 2014, the date on which the provisions of this amended and restated Plan become effective, except as otherwise provided herein. The original Effective Date of the Plan was September 1, 1958.

Section 1.23 Eligible Employee. Any Employee employed by the Employer other than the following:

A. an intern;

B. an Employee covered by a collective bargaining agreement (recognized as such under applicable federal labor law), unless the agreement provides that such Employee is entitled to participate in the Plan or unless the Plan Administrator otherwise directs in a written instrument submitted to the Trustee;

C. any Leased Employee or any independent contractor (as determined by the Employer pursuant to its established payroll practices), regardless of whether a governmental agency, court or other entity subsequently determines such individual to be an Employee);

D. an Employee who is eligible (or would be eligible upon satisfaction of service and/or age criteria) for another Code Section 401(k) plan maintained by an Employer.

An Eligible Employee may become a Participant in the Plan pursuant to the requirements of Article II.

Section 1.24 Employee. Any person who, on or after the Effective Date, is directly employed by the Employer (or any other Related Employer required to be aggregated with the Employer under Code Sections 414(b), (c), (m) or (o)) in a position that the Plan Administrator determines to be subject to tax withholding by the Employer under the Federal Insurance Contribution Act (FICA) and for whom such taxes are regularly withheld by the Employer. To the extent required by Code Section 414(n), the term "Employee" shall include any Leased Employee (who shall nevertheless be ineligible to participate in the Plan). An Employee shall not include an individual providing services to an Employer as an "independent contractor" (e.g., a person (who is not considered to be a Leased Employee) who is engaged as an independent contractor pursuant to a contract or agreement between such person and an Employer which designates him as an independent contractor or otherwise contemplates or implies that he shall function as an independent contractor). Only individuals who are paid as employees from an Employer payroll and treated by an Employer at all times as Employees shall be deemed Employees for purposes of the Plan. No independent contractor shall be treated as an Employee under the Plan during the period he renders services to an Employer as an independent contractor.

If the Employer does not characterize a person as an Employee and the Employer is later required to re-characterize such person's status with the Employer as an Employee, the person will be treated as an Employee under the Plan as of the date of the re-characterization, unless an earlier date is necessary to preserve the tax-qualified status of the Plan. Notwithstanding such general re-characterization, such person shall not be considered an "Eligible Employee" for purposes of Plan participation, except and to the extent necessary to preserve the tax-qualified status of the Plan.

Section 1.25 Employer(s). The Company and any Related Employers that shall ratify and adopt this Plan in a manner satisfactory to, and with the consent of, the Committee; any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. Unless otherwise provided by the Committee, an Employer participating in the Plan shall automatically cease to participate in the Plan on the date that such entity is no longer considered a Related Employer of the Company and any employee of such Employer shall cease to be eligible to make or receive contributions under the Plan as of such date. The Company and any applicable Related Employer may limit or extend the adoption of the Plan and the Trust Agreement to one or more groups of Employees and/or divisions, locations or operations.

Section 1.26 Employment Commencement Date. The date upon which an Employee first performs an Hour of Service for the Employer or a Prior Employer.

Section 1.27 ERISA. The Employee Retirement Income Security Act of 1974, as it may be amended from time to time.

Section 1.28 FAP Benefit. The term used to describe the "Final Average Pay Option" benefit (renamed the "FAP Benefit") in any of the applicable NiSource Pension Plans that offers such a pension benefit as described therein.

Section 1.29 Former Participant. A Participant who has transferred to a classification of Employees ineligible to participate in the Plan, or a Participant whose employment with the Employer has terminated but who has a vested Account balance under the Plan that has not been paid in full and, therefore, is continuing to participate in the allocation of Trust Fund Income.

Section 1.30 Highly Compensated Employee. For a particular Plan Year, any Employee who:

A. at any time during the current or preceding Plan Year was a 5–percent owner (as defined in Code Section 416(i)(1)); or

B. for the preceding Plan Year:

(i) received annual Compensation from the Employer in excess of the amount provided under Code Section 414(q)(1)(B) ($115,000 for 2014 and $120,000 for 2015 and as adjusted by the Secretary of the Treasury thereafter); and

(ii) was in the top 20% of Employees when ranked on the basis of Compensation for the prior Plan Year.

The term Highly Compensated Employee includes a former Employee whose Termination of Employment occurred prior to the Plan Year, and who was a Highly Compensated Employee for the Plan Year in which his Termination of Employment occurred (or was deemed to have occurred) or for any Plan Year ending on or after his 55th birthday.

The determination of who is a Highly Compensated Employee shall be made in accordance with Code Section 414(q) and applicable Treasury Regulations and Internal Revenue Service guidance promulgated thereunder.

Section 1.31 Income. The net gain or loss of the Trust Fund from investments, as reflected by interest payments, dividends, realized and unrealized gains and losses on securities, other investment transactions and expenses paid from the Trust Fund. In determining the Income of the Trust Fund as of any date, assets shall be valued on the basis of their then fair market value.

Section 1.32 Investment Manager. A person or organization who is appointed under Section 10.05 to direct the investment of all or part of the Trust Fund, and who is either (a) registered in good standing as an Investment Adviser under the Investment Advisers Act of 1940, (b) a bank, as defined in that Act, or (c) an insurance company qualified to perform investment management services under the laws of more than one state of the United States, and who has acknowledged in writing that he is a fiduciary with respect to the Plan.

Section 1.33 Kokomo. Kokomo Gas and Fuel Company, or any successor(s). Effective July 1, 2011, Kokomo merged with and into NIPSCO (see "NIPSCO" and "NIPSCO Union Employee" for further details).

Section 1.34 Kokomo Union Pension Plan. The Kokomo Union Pension Plan (f/k/a the Kokomo Gas and Fuel Company Bargaining Unit Employees' Retirement Plan), or any successor plan (as defined therein). Effective December 31, 2012, the Kokomo Union Pension Plan merged with and into the NIPSCO Union Pension Plan.

Section 1.35 Kokomo Union Employee. An Employee who was employed by Kokomo immediately prior to the merger of Kokomo into NIPSCO effective July 1, 2011, whose compensation, conditions of employment or position are covered by a collective bargaining agreement which called for the Employee's participation in the Plan. After the July 1, 2011 merger, the separate Kokomo bargaining unit no longer existed and Kokomo Union Employees became NIPSCO Union Employees. However, see the definition of NIPSCO Union Employee for limitation of this characterization for purposes of the Plan.

Section 1.36 Leased Employee. Any person (other than an Employee of the Employer) who, pursuant to an agreement between the Employer and any other person ("Leasing Organization"), has performed services for the Employer (or for the Employer and related persons determined in accordance with Code Section 414(n)(6)) on a substantially full time basis for a period of at least one year, which services are performed under the primary direction or control of the Employer. Contributions or benefits provided to a Leased Employee by the Leasing Organization that are attributable to services performed for the Employer shall be treated as provided by the Employer. If applicable, Compensation as defined in this Article includes compensation from the Leasing Organization that is attributable to services performed for the Employer.

A Leased Employee shall not be considered an Employee of the Employer if (a) such employee is covered by a money purchase pension plan providing: (i) a nonintegrated employer contribution rate of at least ten percent of compensation, as defined in Code Section 415(c)(3), but including amounts contributed pursuant to a salary reduction agreement that are excludible from the Employee's gross income under Section 125, Section 402(e)(3), Section 402(h) or Section 403(b) of the Code, (ii) immediate participation if such person received $1,000 or more of compensation during the four-year period ending with the measuring plan year, and (iii) full and immediate vesting; and (b) leased employees do not constitute more than 20% of the Employer's nonhighly compensated workforce (within the meaning of Code Section 414(n)(5)(C)(ii)).

Section 1.37 Matching Account. That portion of a Participant's Account credited with Matching Contributions pursuant to Section 3.04, and adjustments relating thereto.

Section 1.38 Next Gen Employee. Any Employee who participates in the "Next Gen" benefit structure offered by the Employer or a Related Employer. A Next Gen Employee does not actively participate in any defined benefit pension plan of the Employer or a Related Employer (*i.e.*, does not accrue a benefit under such plan(s) other than continued accrual of "Interest Credits" as defined in such plan(s) if applicable). A Next Gen Employee is eligible

for the contribution described in Section 3.06C of the Plan and Matching Contributions as described in subsection F of Schedule I. "Next Gen Employee" shall include the following:

A. any "Exempt Employee" (as classified under the payroll practices of the Employer) who is hired or rehired on or after January 1, 2010;

B. any "Springfield C/T Employee" or "Northampton Employee" (as each is defined in Schedule II) who is hired or rehired on or after January 1, 2011;

C. any "Lawrence Employee" or "Brockton Operating Employee" (as each is defined in Schedule II) who is hired or rehired on or after January 1, 2013; and

D. any "Non-Exempt Employee" (as classified under the payroll practices of the Employer) or any Columbia Union Employee who is hired or rehired on or after January 1, 2013; and

E. any "Brockton C/T Employee" (as defined in Schedule II) who is hired or rehired on or after June 1, 2013; and

F. any "Springfield Utility Employee" (as defined in Schedule II) who is hired or rehire on or after January 1, 2014.

Section 1.39 Next Gen Employer Contribution Account That portion of a Participant's Account credited with Next Gen Employer Contributions under Sections 3.06 and 3.07, and adjustments relating thereto.

Section 1.40 NIFL. Northern Indiana Fuel & Light Company, or any successor(s). Effective July 1, 2011, NIFL merged with and into NIPSCO (see "NIPSCO" and "NIPSCO Union Employee" for further details).

Section 1.41 NIFL Union Employee. An Employee who was employed by NIFL immediately prior to the merger of NIFL into NIPSCO effective July 1, 2011, whose compensation, conditions of employment or position are covered by a collective bargaining agreement which called for the Employee's participation in the Plan. After the July 1, 2011 merger, the separate NIFL bargaining unit no longer existed and NIFL Union Employees became NIPSCO Union Employees. However, see the definition of NIPSCO Union Employee for limitation of this characterization for purposes of the Plan.

Section 1.42 NIPSCO. Northern Indiana Public Service Company, or any successor(s). With reference to NIPSCO Union Employees and the NIPSCO 401(k) Plan, "NIPSCO" shall also include NiSource Inc. and any Related Employer that adopts the NIPSCO 401(k) Plan.

Effective July 1, 2011, NIFL and Kokomo merged with and into NIPSCO. References to "NIFL" and "Kokomo" shall continue to apply to the extent that employees employed by NIFL or Kokomo immediately prior to the merger remain subject to the pension plan provisions of either the Subsidiary Plan or the Kokomo Union Pension Plan. Effective December 31, 2012, the Subsidiary Pension Plan and the Kokomo Union Pension Plan merged into the NiSource Salaried Pension Plan and the NIPSCO Union Pension Plan (as applicable). On and after such

date, NIFL Union Employees and Kokomo Union Employees became subject to the provisions of NIPSCO Union Pension Plan, while non-union employees who were employees of NIFL and Kokomo immediate prior to July 1, 2011 became subject to the provisions of the NiSource Salaried Pension Plan.

Section 1.43 NIPSCO 401(k) Plan. The Northern Indiana Public Service Company Bargaining Unit Tax Deferred Savings Plan, which merged into the Plan effective December 31, 2008.

Section 1.44 NIPSCO Union Employee. An Eligible Employee of NIPSCO, whose terms and conditions of employment are governed by a collective bargaining agreement to which NIPSCO is a party and which agreement calls for the Employee's participation in the Plan (or prior to December 31, 2008, in the NIPSCO 401(k) Plan).

Notwithstanding the foregoing, any Eligible Employee who was an employee of Kokomo or NIFL as of June 30, 2011 and transitioned to employment with NIPSCO as part of the July 1, 2011 merger of Kokomo and NIFL with and into NIPSCO shall not be considered a NIPSCO Union Employee for purposes of the Plan to the extent that pension plan provisions applicable to such NIPSCO employees who are former NIFL Union Employees or former Kokomo Union Employees remain in effect and consequently cause the matching contribution benefit structures under the of the Plan to remain unchanged for such employees. Effective December 31, 2012, the Subsidiary Pension Plan and the Kokomo Union Pension Plan merged into the NIPSCO Union Pension Plan; however the provisions of the Subsidiary Pension Plan or Kokomo Union Pension Plan as applicable to NIFL Union Employees or Kokomo Union Employees, respectively, immediately prior to the merger of such entities into NIPSCO effective July 1, 2011 continue to remain in effect under the NIPSCO Pension Plan on and after December 31, 2012 and, accordingly the matching contribution structures for such employees remain unchanged, except in instances where an employee's pension benefit structure changed, such as moving from the AB II Benefit structure to the AB I Benefit structure. Stated otherwise, for purposes of Matching Contributions under the Plan, such former NIFL Union Employees and Kokomo Union Employees are not considered NIPSCO Union Employees.

Section 1.45 NIPSCO Union Pension Plan. The NIPSCO Union Pension Plan (f/k/a the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Bargaining Unit Employees), or any successor plan (as defined therein).

Section 1.46 NiSource Pension Plans. Effective after December 31, 2012, the NiSource Salaried Pension Plan, the Columbia Pension Plan, the Bay State Pension Plan, the Bay State Union Plan, and the NIPSCO Union Pension Plan, (individually and/or collectively, as the context requires).

Section 1.47 NiSource Salaried Pension Plan. The NiSource Salaried Pension Plan (f/k/a the NiSource Inc. and Northern Indiana Public Service Company Pension Plan Provisions Pertaining to Salaried and Non-Exempt Employees), or any successor plan (as defined therein).

Section 1.48 Non-highly Compensated Employee. Any Eligible Employee who is not a Highly Compensated Employee.

Section 1.49 Participant. An Eligible Employee who becomes a Participant in accordance with the provisions of Article II. An Eligible Employee who becomes a Participant shall remain a Participant or Former Participant under the Plan until the Trustee has fully distributed the vested amount standing in his Account to him.

Section 1.50 Period of Service. The period of Service commencing on an Employee's Employment Commencement Date or Re–employment Commencement Date, whichever is applicable, and ending on the date his employment ends. Employment ends on the date the Employee quits, is discharged, retires or dies or (if earlier) the first anniversary of his absence for any other reason. The period of absence starting with the date an Employee's employment ends and ending on the date he next performs an hour of Service is (a) included in his Period of Employment if the period of absence does not exceed one year, and (b) excluded if such period exceeds one year

Section 1.51 Plan. The plan designated as the NiSource Inc. Retirement Savings Plan and sponsored by the Company, as set forth herein or in any amendments hereto.

Section 1.52 Plan 2006 Restatement. The amended and restated document for the Plan effective January 1, 2006.

Section 1.53 Plan Administrator. The Committee, or such delegate of the Committee designated to carry out the administrative functions of the Plan.

Section 1.54 Plan Sponsor. The Company is designated the sponsor of the Plan.

Section 1.55 Plan Year. The fiscal year of the Plan, a 12 consecutive month period commencing on January 1 and ending on December 31.

Section 1.56 Pre–tax Contribution Account. That portion of a Participant's Account credited with Pre–tax Contributions under Section 3.02, and adjustments relating thereto.

Section 1.57 Profit Sharing Account. That portion of a Participant's Account credited with Profit Sharing Contributions under Sections 3.06 and 3.07, and adjustments relating thereto.

Section 1.58 Reemployment Commencement Date. The date upon which an Employee first performs an hour of Service for the Employer following a break in Service.

Section 1.59 Related Employers. A controlled group of corporations (as defined in Code Section 414(b)) that includes the Company; trades or business (whether or not incorporated) which are under common control (as defined in Code Section 414(c)) with the Company; or an affiliated service group (as defined in Code Sections 414(m) and (o)) that includes the Company. If the Employer is a member of a group of Related Employers, the term "Employer" includes the Related Employers as required by the Code or by the Plan, including for purposes of crediting service, applying the coverage test of Code Section 410(b), applying the limitations of Article VII, applying the Top Heavy rules and the minimum benefit requirements of Article XI, the definitions of Employee, Highly Compensated Employee, Compensation, and Leased Employee contained in this Article I. However, only an Employer

as defined in this Article may contribute to the Plan, and only an Eligible Employee as defined in this Article is eligible to participate in this Plan.

Section 1.60 Required Beginning Date. For purposes of Article IV, for any Participant who is not a Five-percent Owner (as defined in Code Section 416(i)), the Required Beginning Date is the April 1 of the calendar year following the later of the calendar year in which the Participant (i) attains age 70½, or (ii) terminates employment with the Employer. For any Participant who is at least a Five-percent Owner (as defined in Code Section 416(i)), the Required Beginning Date is the April 1 immediately following the calendar year in which the Participant attains age 70½, regardless of whether the Participant has retired.

Section 1.61 Rollover Account. That portion of a Participant's Account credited with Rollover Contributions under Section 3.09, and adjustments relating thereto.

Section 1.62 Roth Contribution Account. That portion of a Participant's Account credited with Roth Contributions under section 3.02D, and adjustments relating thereto.

Section 1.63 Service. Any period of time the Employee is in the employ of the Employer, whether before or after adoption of the Plan, determined in accordance with reasonable and uniform standards and policies adopted by the Plan Administrator, which standards and policies shall be consistently observed.

Section 1.64 Severance from Employment. A termination of employment occurring when an Employee ceases to be an Employee of the Employer maintaining the Plan. An Employee does not have a "Severance from Employment" if, in connection with a change of employment, the Employee's new employer maintains the Plan with respect to the Employee.

Section 1.65 Spouse. The spouse of the Participant as recognized under the laws of the State in which the Participant resides. Notwithstanding the foregoing, effective September 16, 2013, the term "Spouse" shall include any individual who is lawfully married to a Participant under any State law, including individuals married to Participants of the same sex who were legally married in a State that recognizes such marriages, but who are domiciled in a State that does not recognize such marriages. For purposes of the foregoing sentence, "State" shall mean any domestic or foreign jurisdiction having legal authority to sanction marriages (*i.e.*, any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, any other territory or possession of the United States, and any foreign jurisdiction having the legal authority to sanction marriages).

Section 1.66 Subsidiary Pension Plan. The NiSource Subsidiary Pension Plan, or any successor plan (as defined therein). Effective December 31, 2012, the Subsidiary Pension Plan merged with and into the NiSource Salaried Pension Plan and the NIPSCO Union Pension Plan (as applicable).

Section 1.67 Transfer Account. That portion of a Participant's Account credited with Transfer Contributions under Section 3.09, and adjustments relating thereto.

Section 1.68 Treasury Regulations. Regulations promulgated under the Internal Revenue Code by the Secretary of the Treasury.

Section 1.69 Trust. The trust maintained in accordance with Article VIII from which benefits provided under the Plan will be paid.

Section 1.70 Trust Agreement. The agreement establishing and maintaining the Trust, as provided for in Article VIII, as the same may be amended from time to time.

Section 1.71 Trust Fund. All property of every kind held or acquired by a Trustee under the Trust Agreement established pursuant to Section 8.01.

Section 1.72 Trustee(s). The individual(s) and/or entity or entities appointed to administer and maintain the Trust in accordance with Article VIII.

Section 1.73 Valuation Date. Each day on which Company Stock is available to be publicly traded.

Section 1.74 Terms Defined Elsewhere.

Actual Contribution Percentage ..... Section 6.01
Actual Deferral Percentage ..... Section 6.01
After-tax Contributions ..... Section 3.02
Annual Additions ..... Section 7.02
Cash-out Distribution ..... Sections 4.03
Catch-up Contributions ..... Section 3.02
Claimant ..... Section 9.09
Determination Date ..... Section 11.06
Direct Rollover ..... Section 5.07
Distributee ..... Section 5.07
Eligible Retirement Plan ..... Section 5.07
Eligible Rollover Distribution ..... Section 5.07
Excess Aggregate Contributions ..... Section 6.01
Excess Amount ..... Section 7.02
Excess Contributions ..... Section 6.01
Excess Elective Deferrals ..... Section 7.01
Exempt Employee ..... Section 1.37
Gap Period ..... Section 7.01
Investment Funds ..... Section 8.05
Key Employee ..... Section 11.06
Limitation Year ..... Section 7.02
Matching Contribution ..... Section 3.04
Maximum Permissible Amount ..... Section 7.02
Non-Exempt Employee ..... Section 1.37
Non-Key Employee ..... Section 11.06
Permissive Aggregation Group ..... Section 11.06
Pre-tax Contributions ..... Section 3.02
Prior Profit Sharing Contributions ..... Section 3.06
Prior Profit Sharing Contributions Account ..... Section 3.06
Profit Sharing Contributions ..... Section 3.06

Required Aggregation Group.....Section 11.06
Rollover Contributions.....Section 3.09
Roth Contributions.....Section 3.02
Section 16(b) Officer.....Section 5.05
Top Heavy.....Section 11.03
Transfer Contributions.....Section 3.09

ARTICLE II

ELIGIBILITY AND PARTICIPATION

Section 2.01 Eligibility. Each Eligible Employee shall be eligible to become a Participant in the Plan. Each Eligible Employee who was a Participant in the Plan on the day before the Effective Date of this restated Plan shall continue as a Participant in this Plan as restated. Except as provided in Schedule II (Bay State Union Employees) prior to January 1, 2014, any other Eligible Employee shall become a Participant effective upon such Eligible Employee's Employment Commencement Date.

A. Enrollment Generally. As soon as administratively practicable, the Plan Administrator shall notify each Eligible Employee that he is eligible to make contributions to the Plan and shall explain the rights, privileges and duties of a Participant in the Plan. Each Eligible Employee may enroll as a Participant in the Pre–tax Contributions, Roth Contributions or the After–tax Contributions portions of the Plan at any time and as soon as administratively practicable on or after his date of hire, by properly completing the enrollment procedures established at the time by the Plan Administrator, or by following such other reasonable procedures as the Plan Administrator may implement. The Plan Administrator may establish rules and procedures governing the time and manner in which enrollments shall be processed.

B. Automatic Enrollment; Notice of Participation. Except as provided herein, all Eligible Employees hired or rehired on or after the Effective Date shall be subject to the automatic enrollment and notice provisions of this subsection B. Notwithstanding the foregoing, the provisions of this subsection B shall not apply to Kokomo Union Employees hired before March 1, 2009, and NIPSCO Union Employees hired before June 1, 2009, who shall instead be subject to the general enrollment provisions set forth in Section 2.01A. In addition, the provisions of this subsection B shall be modified as set forth in Schedule II for Bay State Union Employees (*i.e.*, this subsection applies with varied effective dates for different Bay State Union Employee groups and applies uniformly to all Bay State Union Employees hired on or after January 1, 2014). Pursuant to the provisions of this subsection B, an Eligible Employee shall be automatically enrolled in the Plan as of the first pay period following 30 days after his Employment Commencement Date (or Reemployment Commencement Date). Such Eligible Employee shall be deemed to have elected to contribute the percentage of his Compensation identified below in this subsection as a Pre–tax Contribution (the "Automatic Percentage Amount") in accordance with Section 3.02A of the Plan, unless the Eligible Employee elects to contribute a different percentage of his Compensation or affirmatively elects not to contribute any portion of his Compensation.

(i) For any Eligible Employee hired or rehired on or after January 1, 2008, but before January 1, 2014, the Automatic Percentage Amount shall be 3% of Compensation, subject to the provisions of any applicable collective bargaining agreements.

(ii) For any non-union Eligible Employee hired or rehired on or after January 1, 2014, but before January 1, 2015, the Automatic Percentage Amount shall be 4% of Compensation.

(iii) For any non-union Eligible Employee hired or rehired on or after January 1, 2015, or any NIPSCO Union Employee hired or rehired on or after January 1, 2015, the Automatic Percentage Amount shall be 6% of Compensation, subject to the provisions of any applicable collective bargaining agreements.

By his participation, the Participant shall be deemed to have agreed to abide by the provisions of the Plan. Unless otherwise provided above, the Automatic Percentage Amounts for Bay State Union Employees and NIPSCO Union Employees, and the effective dates thereof, are provided in Schedule II and Schedule III, respectively.

C. Notice. Within a reasonable time (generally 30 to 90 days before each Plan Year, or, in the case of a newly eligible Participant, within the 90 days prior to and including the date of eligibility), the Plan Administrator shall give each Participant that will be or is enrolled in the Plan pursuant to this Section 3.01B a written notice of the Participant's rights and obligations under the Plan's automatic enrollment provisions in accordance with the provisions of Treasury Regulation Section 1.414(w)–1 and subsequent guidance. Such notice generally shall include a description of the following: (i) the circumstances of automatic deferrals; (ii) the Participant's Automatic Percentage Amount; (iii) the Participant's right to make a contrary deferral election as provided in Section 3.02 of the Plan; (iv) how contributions will be invested in the absence of any investment election by the Participant; (v) any Company contributions made on behalf of the Participant; and (vi) the Plan's withdrawal and vesting provisions.

Any contributions pursuant to this automatic enrollment provision shall be reduced or stopped to meet the limitations under Code Sections 401(a)(17), 402(g) and 415 and to satisfy any suspension period required after a hardship distribution as described in Section 5.05.

Section 2.02 Participation Upon Re–Employment. Except as provided in Schedule II, an Eligible Employee who was a Participant shall again become a Participant on his Reemployment Commencement Date.

Section 2.03 Transfers Between Employers. For eligibility purposes, a Participant who transfers employment from one Employer to another Employer shall continue to be eligible to participate in the Plan if such Participant previously met the requirements of Section 2.01. In accordance with the Plan and Code, an Eligible Employee shall continue to be an Eligible Employee following a transfer between Employers as if such Eligible Employee had performed all Service during the Plan Year for the Employer to which the Eligible Employee last transferred.

Section 2.04 Changes in Participant's Job Classification. A Participant who transfers to a classification of Employee that causes him to cease to meet the definition of Eligible Employee, or who is granted a leave of absence or placed on inactive status by an Employer, shall not be deemed to have terminated employment and shall not be entitled to a distribution based upon a Severance from Employment. While such Participant is employed by an Employer but not as an Eligible Employee, or is on an unpaid leave of absence or in inactive status, neither the Participant nor an Employer on his behalf shall make contributions to the Plan other than Rollover Contributions pursuant to Section 3.09. If the Participant is later employed by an Employer, transfers to a classification of Employee which is eligible to participate in the Plan, returns to employment immediately upon expiration of a leave of absence, or is restored to active status, contributions to the Participant's account may resume under all applicable Plan provisions.

Section 2.05 Termination Of Participation. Subject to the provisions of Sections 2.02 and 2.04, an Employee who becomes a Participant shall remain a Participant until he or his Beneficiary is paid his entire Account Balance following his Severance Date.

ARTICLE III

CONTRIBUTIONS

Section 3.01 Individual Accounts. The Plan Administrator, or, if the Plan Administrator so determines, the Trustee, shall maintain an Account for each Participant and Former Participant having an amount to his credit in the Trust Fund. Each Account may be divided into separate subaccounts to the extent necessary to reflect different kinds of contributions, including "Pre–tax Contributions," "Roth Contributions," "Catch–up Contributions," "After–tax Contributions," "Matching Contributions," "Profit Sharing Contributions," "Next Gen Employer Contributions" and "Prior Profit Sharing Contributions, " as defined below. If a Participant has made a "Rollover Contribution" or "Transfer Contribution," as defined below, separate subaccounts shall be established for such contributions as well. The Plan Administrator will make its allocations, or request the Trustee to make its allocations, to the Accounts of the Participants in accordance with the provisions of Section 8.02. The Plan Administrator may direct the Trustee to maintain a temporary segregated investment Account in the name of a Participant to prevent a distortion of income, gain, or loss allocations under Section 8.02. The Plan Administrator shall ensure that records are maintained for all Account allocations and related recordkeeping activities.

Section 3.02 Participant Contributions.

A. Pre–tax Contributions. A Participant may elect to have his Employer make "Pre–tax Contributions" to the Trust on his behalf by following any deferral election procedures established pursuant to Section 3.03. Alternatively, in accordance with the automatic enrollment provisions of Section 2.01B, an Employer may make Pre–tax Contributions to the Trust on an automatic basis without the affirmative election of the Participant. The amount of Pre–tax Contributions that may be made on behalf of a Participant for any designated period shall be deducted from his Compensation and shall equal: (i) such whole percentage of his Compensation, in a range of 1% to 50%, as designated by the Participant in the salary reduction agreement; or (ii) if automatically enrolled pursuant to Section 2.01B, the Automatic Percentage Amount specified therein. For each calendar year or other taxable year of any Participant, each such Participant's Pre–tax contribution shall not exceed $17,500 in 2014 ($18,000 in 2015 or such other dollar amount as the Commissioner of Internal Revenue may subsequently prescribe in accordance with Code Section 402(g)(5)). The Employer shall not make a Pre–tax Contribution to the Trust to the extent that the Contribution would exceed the Participant's "Maximum Permissible Amount" as defined under Section 7.02.

B. Catch–up Contributions. An Employee who is eligible to make Pre–tax Contributions or Roth Contributions under the Plan and who has attained age 50 before the close of the Employee's taxable year shall be eligible to make "Catch–up Contributions" of not less than 1% but not more than 50% of Compensation in accordance with and subject to the limitations of Code Section 414(v). Such Catch–up Contributions shall not be taken into account for purposes of the

provisions of the Plan implementing the required limitations of Code Sections 402(g) and 415. The Plan shall not be treated as failing to satisfy the provisions of the Plan implementing the requirements of Code Section 401(k)(3), 401(k)(11), 401(k))(12), 410(b), or 416, as applicable, by reason of the making of such Catch–up Contributions. For each Plan Year, each Participant's Catch-up Contributions shall not exceed $5,500 in 2014 and $6,000 in 2015 (or such other dollar amount as the Commissioner of Internal Revenue may prescribe in accordance with Code Section 414(v)(2)(B)). Catch–up Contributions may consist of Pre–tax Contributions and/or Roth Contributions at the Participant's election. No Matching Contributions shall be contributed with respect to any Catch–up Contributions elected or deemed to have been made by a Participant.

C. After–tax Contributions. For any Plan Year, each Participant shall be permitted to make contributions on an after–tax basis ("After–tax Contributions") to the Trust in whole percentages between 1% and 25% of the Participant's Compensation per pay period. All Participant After–tax Contribution elections shall be made at the time, in the manner, and subject to the conditions specified by the Plan Administrator, which shall prescribe uniform and nondiscriminatory rules for such elections. The Trustee will maintain a separate account for a Participant's After–tax Contributions to which all income, expenses, gains and losses attributable to such contributions will be allocated. The Plan Administrator may establish whatever further procedures it deems necessary to facilitate After–tax Contributions.

D. Roth Contributions. Effective January 1, 2010, a Participant may elect to have his Employer make "Roth Contributions" to the Trust on his behalf by following the deferral election procedures established pursuant to Section 3.03. Roth Contributions shall be irrevocably designated as Roth Contributions by the Participant in lieu of all or a portion of the Pre–tax Contributions the Participant is eligible to make under Section 3.02A(i) and shall be subject to the Compensation percentage and dollar limitations of Section 3.02A(i). Roth Contributions shall be treated by the Employer as includible in the Participant's income at the time the Participant would have received the amount if not for the cash or deferred election to make the Roth Contributions. A Participant's Roth Contributions shall be allocated to the Roth Contribution Account, a separate account to which all income, expenses, gains and losses attributable to such contributions will be allocated. No contributions other than Roth Contributions and properly attributable earnings will be credited to a Participant's Roth Contribution Account.

Pursuant to the January 1, 2010 effective date for the election of Roth Contributions noted above, any reference to Roth Contributions in this document is applicable only on and after such date.

Notwithstanding anything in the Plan to the contrary, the sum of a Participant's Pre–tax Contributions, Catch–up Contributions, Roth Contributions and After–tax Contributions shall not exceed 75% of such Participant's Compensation.

Section 3.03 Elections, Changes and Suspensions of Participant Contributions. A Participant's Compensation for a Plan Year shall be reduced by the amount of the allocation he elects for such Plan Year. All elections shall be made at the time, in the manner, and subject to the conditions specified by the Plan Administrator, which shall prescribe uniform and nondiscriminatory rules for such elections, and shall become effective as of the first pay period as is administratively practicable after the election is properly made.

A Participant may change the rate of Pre–tax Contributions (including Catch–up Contributions, if any), Roth Contributions or After–tax Contributions to his Account at any time during each Plan Year, effective for the first payroll period for which it is administratively feasible to change the rate of such Participant's Pre–tax Contributions (including Catch–up Contributions, if any), Roth Contributions or After–tax Contributions, by communicating such rate change in accordance with uniform rules and procedures established by the Plan Administrator regarding the timing and manner of making such elections. In addition, a Participant may at any time elect to suspend all contributions to his Account by giving advance notice in any manner specified by the Plan Administrator in accordance with its uniform rules and procedures. An election to recommence contributions shall be effective for the first payroll period in which it is administratively feasible to begin deferral withholdings. All suspensions and recommencements of Pre–tax Contributions (including Catch–up Contributions, if any), Roth Contributions or After–tax Contributions shall be made in the manner and at the times specified in uniform rules and procedures established by the Plan Administrator, which rules and procedures may be changed from time to time.

Section 3.04 Matching Contributions. For each payroll period or such other interval as established by the Plan Administrator, each Employer shall deposit a "Matching Contribution" to the Trust in an amount provided in Schedule I. The Matching Contributions shall be allocated and invested in accordance with the provisions of Section 3.05. The Employer shall not make a Matching Contribution to the Trust for any Participant to the extent that the contribution would exceed the Participant's "Maximum Permissible Amount" under Section 7.02.

Section 3.05 Matching Contribution Allocation and Accrual of Benefit. Only Participants who have made Pre–tax Contributions, Roth Contributions or certain After–tax Contributions during the payroll period (or such other established interval) shall be eligible to share in the allocation of the Matching Contribution as set forth in Section 3.04 and Schedule I. No Matching Contributions shall be made, however, with respect to Catch–up Contributions.

Except as provided in Schedule II, all Matching Contributions shall be allocated to the Company Stock Fund, pursuant to Section 8.07 and 8.08. All Matching Contributions shall be 100% vested and nonforfeitable at all times.

Section 3.06 Profit Sharing Contributions and Next Gen Employer Contributions. Except as provided in subparagraph C below, for each Plan Year, the Employer may contribute to the Trust amounts determined in its discretion. Such contributions will be in the form of "Profit Sharing Contributions" (previously designated "Profit Participation Contributions" in the Plan 2006 Restatement) as described in subparagraph A and B below. In addition, as provided

in subparagraph C below, the Employer shall make the "Next Gen Employer Contribution" described therein.

A. Amount of Profit Sharing Contribution. The Profit Sharing Contribution made for a Plan Year shall be a stated percentage of the Compensation of the Participants entitled to receive allocations of such Profit Sharing Contribution for such Plan Year in accordance with the eligibility and allocation provisions set forth in Plan Section 3.07. The applicable percentage for each Plan Year shall be designated by the Committee, in its discretion exercised on a non-discriminatory basis, no later than the last day of the first quarter of the Plan Year following the Plan Year for which such percentage is applicable. For purposes of this Section 3.06A, Compensation for a Plan Year shall be defined as determined under the Annual Incentive Plan of an Employer in effect for such Plan Year, reduced by any amounts deferred to a nonqualified plan maintained by an Employer, as described in the definition of Compensation in Article I of the Plan. In allocating a Profit Sharing Contribution to a Participant's Account, the Plan Administrator, subject to Section 11.01, shall take into account only Compensation paid to the Employee during the portion of the Plan Year during which the Employee was a Participant. In no event shall a Profit Sharing Contribution be made with respect to any Participant for any Plan Year to the extent such Profit Sharing Contribution would cause the limitations of Code Section 415 to be exceeded for such Participant for such Plan Year.

B. Prior Profit Sharing Contributions. Prior to January 1, 2002, the Employer contributed other amounts as Profit Sharing Contributions to Participants as described in the Plan 2006 Restatement. The provisions relating to these "Prior Profit Sharing Contributions" including rules and conditions for eligibility, allocation, vesting, forfeitures, and investments, apply as set forth in the Plan 2006 Restatement. The Plan Administrator and/or Trustee shall maintain a "Prior Profit Sharing Contributions Account" to the extent that such contributions require a subaccount that is separate from the Profit Sharing Account.

C. Next Gen Employer Contributions. Notwithstanding the foregoing, effective as of January 1, 2010, the Employer shall contribute each pay period to the Account of each Participant who is both an Eligible Employee and a Next Gen Employee at such time an amount equal to 3% of such Participant's total Compensation for that pay period (as defined in Article I). Such contribution shall be a "Next Gen Employer Contribution." This amount shall be payable to applicable Participants regardless of whether such Participants have elected to make Pre-Tax Contributions, Roth Contributions or any other elective deferrals to the Plan and regardless of the Participants' status as of the end of the Plan Year. As provided in Section 3.07B, this Next Gen Employer Contribution shall be allocated to the Company Stock Fund and shall be 100% vested and nonforfeitable at all times. Eligibility for a Next Gen Employer Contribution under this subparagraph C shall not preclude eligibility for any other Profit Sharing Contribution under the terms contained herein.

Section 3.07 Profit Sharing and Next Gen Employer Contribution Allocation / Investment.

A. Eligibility and Accrual. Each Eligible Employee meeting the allocation requirements of this Section is entitled to participate in Profit Sharing Contributions; provided, however, that if an Eligible Employee is subject to a collective bargaining agreement, such agreement must provide that the Employee is eligible for Profit Sharing Contributions. For Profit Sharing Contributions other than those Next Gen Employer Contributions described in Section 3.06C, the Plan Administrator shall determine the accrual of a Profit Sharing Participant's benefit on the basis of the Plan Year. Although contributions may be made at other times (and therefore credited to Accounts at such other times), the Participant's status as of the end of the Plan Year for which the contribution is made shall determine his entitlement to share in an allocation of such contribution, regardless of when credited to his Account. For Profit Sharing Contributions other than Next Gen Employer Contributions described in Section 3.06C, the Plan Administrator shall not allocate any portion of a Profit Sharing Contribution for a Plan Year to the Account of any Participant, if such Participant is not employed by the Employer on the last day of that Plan Year (for a reason other than retirement, Disability, or death). The Plan shall suspend the accrual requirement described herein if the Plan fails to satisfy the requirements of Code Section 410(b). Notwithstanding any other provision to the contrary, a Profit Sharing Contribution or Next Gen Employer Contribution shall not be allocated to a Participant's Account to the extent the contribution would exceed the Participant's "Maximum Permissible Amount" under Section 7.02.

B. Allocation, Investment and Vesting. Subject to Article XI and except as provided for contributions described under section 3.06C, the Plan Administrator shall allocate and credit to the Account of each Participant who satisfies the conditions of Section 3.07A a percentage of the annual Profit Sharing Contribution in the ratio that the sum of the Participant's total Compensation for the Plan Year bears to the sum of all such Participants' total Compensation for the Plan Year. All Profit Sharing Contributions, including Next Gen Employer Contributions under Section 3.06C, shall be allocated to the Company Stock Fund, pursuant to Section 8.07 and 8.08. All Profit Sharing Contributions, including Next Gen Employer Contributions under Section 3.06C, shall be 100% vested and nonforfeitable at all times.

Section 3.08 Time and Form of Payment of Contribution. The Employer may pay its contribution for each Plan Year in one or more installment payments without interest. In the discretion of the Committee, such payments may be made to the Plan in the form of cash or Company Stock. The Employer must make its contribution which Participants have elected to defer under Section 3.02 as soon as such amounts may reasonably be segregated from the Employer's general assets, but in no event later than 15 business days after the end of the calendar month in which such amounts were withheld from the Participant's Compensation, or such later time as may be permitted by regulations under ERISA and Code Section 401(k). The

Employer must make the balance, if any, of its contribution to the Trustee within the time prescribed (including extensions) for filing its tax return for the taxable year for which it claims a deduction for its contribution, in accordance with Code Section 404(a)(6).

Section 3.09 Rollover and Transfer Contributions. The Trustee is authorized to accept and hold as part of the Trust Fund, assets transferred on behalf of an Employee, provided that such transfer satisfied any procedures or other requirements established by the Plan Administrator. The Trustee shall also accept and hold as part of the Trust Fund assets transferred in connection with a merger or consolidation of another plan with or into the Plan pursuant to Section 14.05 hereof and as may be approved by the Committee. In addition, the Trustee shall also accept "rollover" amounts (other than amounts attributable to after–tax contributions and earnings thereon) contributed directly by or on behalf of an Employee in accordance with procedures and rules established by the Plan Administrator in respect of a distribution made to or on behalf of such Employee from another plan pursuant to Section 14.05 hereof. All amounts so transferred to the Trust Fund shall be held in segregated subaccounts and shall be referred to as "Transfer Contributions" if such amounts are subject to the special distribution rules described in Section 14.05 and as ""Rollover Contributions" if not subject to such rules. Rollover Contributions must conform to rules and procedures established by the Plan Administrator, including rules designed to assure the Plan Administrator that the funds so transferred qualify as a Rollover Contribution under the Code, including the rules specified in Section 5.07D herein.

Section 3.10 Return of Contributions. All contributions to the Plan are conditioned upon their deductibility under the Code. The Trustee, upon written request from the Plan Administrator, shall return to the Employer the amount of the Employer's contribution made by the Employer by mistake of fact or the amount of the Employer's contribution disallowed as a deduction under Code Section 404. The Trustee shall not return any portion of the Employer's contribution under this provision more than one year after:

A. The Employer made the contribution by mistake of fact; or

B. The disallowance of the contribution as a deduction, and then, only to the extent of the disallowance.

The Trustee shall not increase the amount of the Employer contribution returnable under this Section for any earnings attributable to the contribution, but the Trustee shall decrease the Employer contribution returnable for any losses attributable to it. The Trustee may require the Employer to furnish it whatever evidence the Trustee deems necessary to enable the Trustee to confirm the amount the Employer has requested be returned is properly returnable under ERISA.

ARTICLE IV

VESTING; TIME AND METHOD OF PAYMENT OF BENEFITS

Section 4.01 Vested Benefit. A Participant's interest in his Account shall at all times be fully vested and nonforfeitable.

Section 4.02 Distribution Upon Severance From Employment, Disability or Death. Upon a Participant's Severance from Employment, Disability or death, the Participant (or in the event of death, the Beneficiary) shall be entitled to receive the Participant's entire Account Balance (reduced by any amount attributable to an outstanding loan made by the Participant pursuant to Section 5.08) in accordance with the provisions of this Article IV.

Section 4.03 Payment Timing. Upon Severance from Employment before age 65, the Trustee shall, subject to the consent requirements described in this Section, distribute the Participant's Account Balance as set forth below. For purposes of the distribution timing rules, a "Cash–out Distribution" is a lump sum distribution of the Participant's Account Balance.

A. Timing Based on Account Balance Amount.

(i) If the Participant's Account Balance on the date the distribution commences is $1,000 or less ($5,000 prior to March 28, 2005), the Trustee shall pay such Account Balance to the Participant in the form of a single, lump sum Cash–out Distribution as soon as administratively practicable after the Participant's Severance from Employment.

(ii) If the Participant's Account Balance on the date the distribution commences is more than $1,000 but less than $5,000, any distribution shall be automatically rolled over to an individual retirement account in the name of the Participant in accordance with Code Section 401(a)(31)(B)(i) and related regulations, unless the Participant otherwise consents to the distributions. For purposes of applying the rollover provisions of this subparagraph (ii) to an Account Balance consisting at least in part of a Roth Contribution Account, the amount of the Roth Contribution Account may be considered separately from the non-Roth portions of the Participant's Account Balance for the sole purpose of determining whether such Roth Contribution Account shall be automatically rolled over to an individual retirement account under this subparagraph (ii) or paid to the Participant in the form of a single lump-sum distribution under subparagraph (i) above.

(iii) If the Participant's Account Balance on the date the distribution commences is greater than $5,000, such distribution shall be deferred until the Participant consents to the distribution (but no later than the Participant's Required Beginning Date).

B. Deferral of Distribution. If the Participant does not file his written consent (if required) with the Trustee within the reasonable period of time stated in the consent form, the Trustee shall continue to hold the Participant's Account in trust until the Participant files an application for distribution with the Plan Administrator. At that time, the Trustee shall commence payment of the Participant's Account in accordance with the provisions of this Article IV; provided, however, if the Participant dies after terminating employment but prior to attaining age 65, the Plan Administrator, upon notice of the death and application for benefits filed by the Beneficiary, shall direct the Trustee to commence payment of the Participant's Account to his Beneficiary in accordance with the provisions of Section 4.05.

C. Consent Requirements. The Participant must consent in writing to the Plan Administrator's direction to the Trustee to make a distribution to the Participant and to the form of the distribution if: (i) the Participant's Account Balance on the date the distribution commences exceeds $1,000 ($5,000 prior to March 28, 2005), and (ii) the Plan Administrator directs the Trustee to make a distribution to the Participant prior to his attaining age 65.

The Plan Administrator shall notify the Participant of the right to defer any distribution until the Participant's Account Balance is no longer immediately distributable. For any such notification after December 31, 2006, the description of a Participant's right to defer receipt of a distribution will describe the consequences of failing to defer receipt, as required by regulations under Code Section 411(a)(11). Such notice shall be provided no less than 30 days and no more than 180 days prior to the date of distribution. However, if the Participant, after having received this notice, affirmatively elects a distribution, such distribution may commence less than 30 days after the notice was provided.

The consent of the Participant shall not be required to the extent that a distribution is required to satisfy Code Section 401(a)(9) or Code Section 415. An Account balance is immediately distributable if any part of the Account balance could be distributed to the Participant (or the surviving Spouse) before the Participant attains, or would have attained if not deceased, age 65.

D. Minimum Legal Distribution Requirements. Unless the Participant elects otherwise in writing, the Participant's Account Balance shall be distributed not later than 60 days after the close of the Plan Year in which the later of the following events occurs:

(i) The date the Participant attains age 65; or

(ii) The date the Participant dies, becomes disabled, or otherwise terminates Service (employment) with the Employer.

In no event shall the distribution commence, nor shall the Participant elect to have distribution commence, later than the Required Beginning Date.

Furthermore, once distributions have begun to a Five–percent Owner (as defined in Code Section 416(i)), they must continue to be distributed, even if the Participant ceases to be a Five–percent Owner in a subsequent year.

In no event shall the payment commence later than the time prescribed by this Article IV or in a form not permitted under Article IV. The Plan Administrator shall make its determinations under this Article IV in a nondiscriminatory, consistent and uniform manner. The Participant shall be provided with the appropriate form to consent to the distribution direction, if required.

Section 4.04 Form of Benefit Payment. A Participant shall receive payment of his Account Balance in one of the following forms:

A. In a single lump sum payment in cash, or if elected by the Participant or Beneficiary, in shares of Company Stock based on the number of whole shares allocated to the Company Stock Fund for the Participant; or

B. In a partial lump sum payment in cash or, if elected by the Participant or Beneficiary, in shares of Company Stock, with the remainder of the Account paid later as elected by the Participant pursuant to this Section.

C. In annual, semi–annual, quarterly, or monthly installments, on an equal or decrementing counter basis.

Notwithstanding the preceding provisions of this Section, unless the Participant otherwise elects, the distribution of the balance in his Account invested in the Company Stock Fund shall be in substantially equal annual or more frequent payments over a period not longer than the greater of five years, or in the case of the Participant whose balance in the portion of his Account invested in the Company Stock Fund exceeds $885,000, five years plus one additional year (but not more than five additional years) for each $175,000 or fraction thereof by which such balance exceeds $885,000, as adjusted pursuant to Code Section 409(o)(2).

Section 4.05 Distributions Upon Death. Upon the death of the Participant, the Participant's Account Balance shall be paid in accordance with Code Section 401(a)(9) and Plan Sections 4.03 and 4.04.

In the case of a death or disability occurring on or after January 1, 2007, if a Participant dies while performing qualified military service (as defined in Code Section 414(u)), the survivors of the Participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the Plan as if the Participant had resumed and then terminated employment on account of death.

Section 4.06 Revised Required Minimum Distributions. The Participant's Account Balance shall be distributed, as of the Required Beginning Date, in accordance with the minimum distribution requirements established by Code Section 401(a)(9) and the applicable Treasury Regulations thereunder.

A. Effective Dates. Effective January 1, 2003, the Plan shall apply the provisions of this Section 4.06 for purposes of determining the required minimum distributions for calendar years beginning on or after January 1, 2003.

B. Definitions. For purposes of this Section 4.06, the following definitions shall apply:

"Designated Beneficiary" is the individual who is designated as the beneficiary under the Plan and is the Designated Beneficiary under Code Section 401(a)(9) and Section 1.401(a)(9)–1, Q&A–4 of the Treasury Regulations.

"Distribution Calendar Year" is a calendar year for which a minimum distribution is required. For distributions beginning before the Participant's death, the first Distribution Calendar Year is the calendar year immediately preceding the calendar year which contains the Participant's Required Beginning Date. For distributions beginning after the Participant's death, the first Distribution Calendar Year is the calendar year in which the distributions are required to begin. The required minimum distribution for the Participant's first Distribution Calendar Year will be made on or before the Participant's Required Beginning Date. The required minimum distribution for other Distribution Calendar Years, including the required minimum distribution for the Distribution Calendar Year in which the Participant's Required Beginning Date occurs, will be made on or before December 31 of that Distribution Calendar Year.

"Life Expectancy" is a beneficiary's life expectancy as computed by use of the Single Life Table in Section 1.401(a)(9)–9 of the Treasury Regulations.

"Participant's Account Balance" is the Account Balance as of the last valuation date in the calendar year immediately preceding the Distribution Calendar Year (the "Valuation Calendar Year") increased by the amount of any contributions made and allocated or forfeitures allocated to the Account Balance as of dates in the Valuation Calendar Year after the valuation date and decreased by distributions made in the Valuation Calendar Year after the valuation date. The Account Balance for the Valuation Calendar Year includes any amounts rolled over or transferred to the Plan either in the Valuation Calendar Year or in the Distribution Calendar Year if distributed or transferred in the Valuation Calendar Year.

C. Time And Manner of Distribution.

(i) Required Beginning Date. The Participant's entire interest will be distributed, or begin to be distributed, to the Participant no later than the Participant's Required Beginning Date.

(ii) Death of Participant Before Distributions Begin. Subject to the provisions of Section 4.06F, if the Participant dies before distributions begin, the

Participant's entire interest will be distributed, or begin to be distributed, no later than as follows:

a. If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, then, except as provided herein, distributions to the surviving Spouse will begin by December 31 of the calendar year immediately following the calendar year in which the Participant died, or by December 31 of the calendar year in which the Participant would have attained age 70½, if later.

b. If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, then, except as provided herein, distributions to the Designated Beneficiary will begin by December 31 of the calendar year immediately following the calendar year in which the Participant died.

c. If there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, the Participant's entire interest will be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

d. If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary and the surviving Spouse dies after the Participant but before distributions to the surviving Spouse begin, this Section 4.06C(ii), other than subsection a, above, will apply as if the surviving Spouse were the Participant.

For purposes of this Section 4.06C(ii) and Section 4.06E, unless subsection d, above applies, distributions are considered to begin on the Participant's Required Beginning Date. If subsection d applies, distributions are considered to begin on the date distributions are required to begin to the surviving Spouse under subsection a, above. If distributions under an annuity purchased from an insurance company irrevocably commence to the Participant before the Participant's Required Beginning Date (or to the Participant's surviving Spouse before the date distributions are required to begin to the surviving Spouse under subsection a, above), the date distributions are considered to begin is the date distributions actually commence.

(iii) Forms of Distribution. Unless the Participant's interest is distributed in the form of an annuity purchased from an insurance company or in a single sum on or before the Required beginning Date, as of the first Distribution Calendar Year distributions will be made in accordance with Sections 4.06D and 4.06E. If the Participant's interest is distributed in the form of an annuity purchased from an insurance company, distributions thereunder will be made in accordance with Code Section 401(a)(9) and the Treasury Regulations.

D. Required Minimum Distributions During Participant's Lifetime.

(i) Amount of Required Minimum Distributions for Each Distribution Calendar Year. During the Participant's lifetime, the minimum amount that will be distributed for each Distribution Calendar Year is the lesser of:

a. the quotient obtained by dividing the Participant's Account Balance by the distribution period in the Uniform Lifetime Table set forth in Treasury Regulations Section 1.401(a)(9)–9, using the Participant's age as of the Participant's birthday in the Distribution Calendar Year; or

b. if the Participant's sole Designated Beneficiary for the Distribution Calendar Year is the Participant's Spouse, the quotient obtained by dividing the Participant's Account Balance by the number in the Joint and Last Survivor Table set forth in Treasury Regulations Section 1.401(a)(9)–9, using the Participant's and the Spouse's attained ages as of the Participant's and Spouse's birthdays in the Distribution Calendar Year.

(ii) Lifetime Required Minimum Distributions Continue Through Year of Participant's Death. Required minimum distributions will be determined under this Section 4.06D beginning with the first Distribution Calendar Year and up to and including the Distribution Calendar Year that includes the Participant's date of death.

E. Required Minimum Distributions After Participant's Death.

(i) Death On or After Date Distributions Begin.

a. Participant Survived by Designated Beneficiary. If the Participant dies on or after the date distributions begin and there is a Designated Beneficiary, the minimum amount that will be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the longer of the remaining Life Expectancy of the Participant or the remaining Life Expectancy of the Participant's Designated Beneficiary, determined as follows:

1. The Participant's remaining Life Expectancy is calculated using the age of the Participant in the year of death, reduced by one for each subsequent year.

2. If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, the remaining Life Expectancy of the surviving Spouse is calculated for each Distribution Calendar Year after the year of the Participant's death using the surviving Spouse's age as of the Spouse's birthday in

that year. For Distribution Calendar Years after the year of the surviving Spouse's death, the remaining Life Expectancy of the surviving Spouse is calculated using the age of the surviving Spouse as of the Spouse's birthday in the calendar year of the Spouse's death, reduced by one for each subsequent calendar year.

3. If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, the Designated Beneficiary's remaining Life Expectancy is calculated using the age of the Beneficiary in the year following the year of the Participant's death, reduced by one for each subsequent year.

b. No Designated Beneficiary. If the Participant dies on or after the date distributions begin and there is no Designated Beneficiary as of September 30 of the year after the year of the Participant's death, the minimum amount that will be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the Participant's remaining Life Expectancy calculated using the age of the Participant in the year of death, reduced by one for each subsequent year.

(ii) Death Before Date Distributions Begin.

a. Participant Survived by Designated Beneficiary. Except as provided herein, if the Participant dies before the date distributions begin and there is a Designated Beneficiary, the minimum amount that will be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the remaining Life Expectancy of the Participant's Designated Beneficiary, determined as provided in Section 4.06E(i).

b. No Designated Beneficiary. If the Participant dies before the date distributions begin and there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, distribution of the Participant's entire interest will be completed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

c. Death of Surviving Spouse Before Distributions to Surviving Spouse are Required to Begin. If the Participant dies before the date distributions begin, the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, and the surviving Spouse dies before distributions are required to begin to the

surviving Spouse under Section 4.06C(ii)(a), this Section 4.06E(ii) will apply as if the surviving Spouse were the Participant.

F. Election to Apply 5-Year Rule to Distributions to Designated Beneficiaries. If the Participant dies before distributions begin and there is a Designated Beneficiary, distribution to the Designated Beneficiary is not required to begin by the date specified in Section 4.06C(ii) of the Plan, but the Participant's entire interest will be distributed to the Designated Beneficiary by December 31 of the calendar year containing the fifth anniversary of the Participant's death. If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary and the surviving Spouse dies after the Participant but before distributions to either the Participant or the surviving Spouse begin, this election will apply as if the surviving Spouse were the Participant. This election will apply to all distributions.

G. Special Provisions Regarding 2009 Required Minimum Distributions.

(i) Default Provision. Notwithstanding the preceding provisions of this Section 4.06, a participant or beneficiary who would have been required to receive required minimum distributions for the 2009 calendar year under this Section and under the minimum distribution requirements of Code Section 401(a)(9) and applicable regulations thereunder, but for the enactment of section 401(a)(9)(H) of the Code (hereinafter "2009 RMDs"), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2009 RMDs or (2) one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the participant, the joint lives (or joint life expectancy) of the participant and the participant's designated beneficiary, or for a period of at least 10 years ("Extended 2009 RMDs"), will not receive those distributions for 2009 unless the participant or beneficiary chooses to receive such distributions.

(ii) 2009 Election. Participants and Beneficiaries described in the preceding paragraph will be given the opportunity to elect to receive the distributions described therein. In addition, notwithstanding this Section 4.06, and solely for purposes of applying the direct rollover provisions of the Plan, distributions of 2009 RMDs and Extended 2009 RMDs that would not be eligible rollover distributions without regard to section 401(a)(9)(H) will be treated as eligible rollover distributions.

Section 4.07 Designation of Beneficiary. A Participant may, from time to time, designate in writing a Beneficiary or Beneficiaries, contingently or successively, to whom the Trustee shall pay his Account in the event of his death. A Participant's Beneficiary designation shall not be valid unless the Participant's Spouse consents (in accordance with the requirements of Code Section 417) to the Beneficiary designation. A Participant's Beneficiary designation does not require spousal consent if the Participant's Spouse is the Participant's designated

Beneficiary. The Plan Administrator shall prescribe the form for the written designation of Beneficiary and, upon the Participant's filing the form with the Plan Administrator, the Participant shall effectively revoke all designations filed prior to that date by the same Participant.

The Plan Administrator may determine the identity of the distributees of any benefit payable under the Plan and in so doing may act and rely upon any information it may deem reliable upon reasonable inquiry, and upon any affidavit, certificate or other paper believed by it to be genuine, and upon any evidence believed by it sufficient. Any payment made in accordance with this Section shall be a complete discharge of obligations of the Plan Administrator and the Employers to the extent of such payment without regard to the application of any payment so made.

Section 4.08 Failure of Beneficiary Designation. If a Participant fails to name a Beneficiary in accordance with Section 4.07, or if the Beneficiary named by a Participant predeceases him, then the Participant's benefits otherwise payable pursuant to this Section shall be paid:

A. to his surviving Spouse, or if none,

B. to his descendants, per stirpes, or if none,

C. to his father and mother, in equal parts, or if none,

D. to his brothers and sisters, in equal parts, or if none,

E. to his estate.

Section 4.09 Special Rules for Transfer Accounts. By operation of relevant law and regulation (including, but not limited to, ERISA and the Code), any Participant who has one or more Transfer Accounts consisting in whole or in part of Transfer Contributions which, must be distributed or made available under the same terms and conditions under which amounts held thereunder were previously held (prior to their becoming Transfer Contributions), Accordingly, notwithstanding any provision of this Article IV to the contrary, but only to the extent required to comply with Code Section 411(d)(6), the Plan Administrator shall, upon the written request of the Participant (in the case of optional forms of benefit), cause the Trustee to distribute or make available such Transfer Contributions at such times and in such manner as may be so required.

Section 4.10 Distributions Under Domestic Relations Orders. Nothing contained in this Plan shall prevent the Trustee from complying with the provisions of a qualified domestic relations order (as defined in Code Section 414(p)). This Plan specifically permits distribution to an alternate payee under a qualified domestic relations order at any time, irrespective of whether the Participant has attained his earliest retirement age (as defined under Code Section 414(p)) under the Plan. A distribution to an alternate payee prior to the Participant's attainment of the earliest retirement age is available only if the order specifies distribution at that time or permits an agreement between the Plan and the alternate payee to authorize such an earlier distribution. Nothing in this Section gives a Participant the right to receive a distribution at a

time not permitted under the Plan, nor does this Section give the alternate payee the right to receive a form of payment not permitted under the Plan.

The Plan Administrator shall establish reasonable procedures to determine the qualified status of a domestic relations order. Upon receiving a domestic relations order, the Plan Administrator promptly shall notify the Participant and any alternate payee named in the order, in writing, of the receipt of the order and the Plan's procedures for determining the qualified status of the order. Within a reasonable period of time after receiving the domestic relations order, the Plan Administrator shall determine the qualified status of the order and shall notify the Participant and each alternate payee, in writing, of its determination. The Plan Administrator shall provide notice under this paragraph by mailing to the individual's address specified in the domestic relations order, or in a manner consistent with Labor Regulations.

If any portion of the Participant's Account Balance is payable during the period the Plan Administrator is making its determination of the qualified status of the domestic relations order, the Trustee shall segregate the amounts payable in a separate account and to invest the segregated account solely in fixed income investments or to maintain a separate bookkeeping account of said amounts. If the Plan Administrator determines the order is a qualified domestic relations order within 18 months of the first date on which payments were due under the terms of the order, the the Plan Administrator shall direct the Trustee to distribute the separate account in accordance with the order. If the Plan Administrator does not make its determination of the qualified status of the order within the above-described 18-month period, the Plan Administrator shall direct the Trustee to distribute the segregated account in the manner the Plan would distribute it if the order did not exist, and shall apply the order prospectively if the Plan Administrator later determines the order is a qualified domestic relations order.

To the extent it is not inconsistent with the provisions of the qualified domestic relations order, the Plan Administrator may direct the Trustee to invest any partitioned amount in a segregated subaccount or separate account and to invest the account in the money market investment option or in other fixed income investments. A segregated subaccount shall remain a part of the Trust, but it alone shall share in any income it earns, and it alone shall bear any expense or loss it incurs.

The Trustee shall make any payment or distributions required under this Section by separate benefit checks or other separate distribution to the alternate payee(s).

Effective April 6, 2007, a domestic relations order that otherwise satisfies the requirements of a qualified domestic relations order as defined in Section 414(p) of the Code and Section 206(d)(3)(B) of ERISA will not fail to be a qualified domestic relations order: (i) solely because the order is issued after, or revises, another domestic relations order or qualified domestic relations order; or (ii) solely because of the time at which the order is issued, including issuance after the Participant begins receipt of benefits or after the Participant's death. Such a domestic relations order is subject to the same requirements and protections that apply to qualified domestic relations orders.

Section 4.11 Lost Participant or Beneficiary. The Account of a Participant shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or

his Beneficiary to whom payment is due. The Plan Administrator may allocate the forfeited Account in accordance with Section 10.21. However, any such forfeited Account will be reinstated and become payable if a claim is made by the Participant or Beneficiary for such Account. The Plan Administrator shall prescribe uniform and non-discriminatory rules for carrying out this provision.

Section 4.12 Facility of Payment. If any person entitled to receive any amount under the provisions of this Plan is determined to be incapable of receiving or disbursing the same by reason of minority, illness or infirmity, mental incompetence, or incapacity of any kind, the Plan Administrator may, in its discretion, direct the Trustee to take any one or more of the following actions:

A. To apply such amount directly for the comfort, support and maintenance of such person;

B. To reimburse any person for any such support theretofore supplied to the person entitled to receive any such payment;

C. To pay such amount to any person selected by the Plan Administrator to disburse it for such comfort, support and maintenance, including without limitation, any relative who has undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution in whose care or custody the person entitled to the amount may be. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any savings or commercial bank of the Plan Administrator's choice, direct that such distribution be paid to the legal guardian, or if none, to a parent of such person or a responsible adult with whom the minor maintains his residence, or to the custodian for such Beneficiary under the Uniform Gift to Minors Act or gift to Minors Act, if such is permitted by the laws of the state in which such minor Beneficiary resides.

Payment pursuant to this Section shall fully discharge the Company, Committee, Trustee, Employer and the Plan from further liability on account thereof.

Section 4.13 No Distribution Prior to Severance From Employment, Death or Disability. Except as provided below, Pre-tax Contributions, Roth Contributions and Catch-up Contributions, and income allocable to each, are not distributable to a Participant or his Beneficiary or Beneficiaries, in accordance with such Participant's or Beneficiary's election, earlier than upon Severance from Employment, death or Disability.

Such amounts may also be distributed upon:

A. Termination of the Plan without the establishment of another defined contribution plan, as defined in the Code and applicable Treasury Regulations.

B. The hardship of the Participant, as described in Section 5.05 herein.

C. The attainment by the Participant of age 59½, as described in Section 5.04 herein.

All distributions that may be made pursuant to one or more of the foregoing distributable events are subject to the spousal and Participant consent requirements (if applicable) contained in Sections 401(a)(11) and 417 of the Code.

Section 4.14 Written Instruction Not Required. Any elections made or distributions processed under this Article IV may be accomplished through telephonic or similar instructions in accordance with the rules and procedures established by the Plan Administrator, to the extent they are consistent with the requirements of the Code and ERISA. Notwithstanding the foregoing, however, spousal consents and waivers, to the extent required, may only be granted in writing.

ARTICLE V

WITHDRAWALS; DIRECT ROLLOVERS AND WITHHOLDING; LOANS

Section 5.01 General Rules. This Article provides the rules that apply to a Participant's request for a withdrawal from the Plan while the Participant is employed by an Employer.

A. A Participant's Account Balance, for purposes of in–service withdrawals shall be determined as of the Valuation Date coinciding with or immediately succeeding the date the request for withdrawal specified in such Sections is delivered to the Plan Administrator.

B. Any withdrawal under Section 5.02, 5.03, 5.04 or 5.05 shall be paid to the Participant as soon as is reasonably practicable.

C. All rules governing withdrawal privileges under this Article shall be administered by the Plan Administrator or its delegate in a uniform manner, and are subject to the claims procedure described in Section 9.07.

D. Any election to begin, change or cease withdrawals shall be made in accordance with procedures established by the Plan Administrator or in such other manner as permitted by the Plan Administrator. Payment of amounts so requested shall be made within an administratively reasonable period of time after the withdrawal has been requested. The Plan Administrator may establish other rules of uniform applicability regarding the timing of and procedures for such withdrawals.

E. Any withdrawals under this Article V may be made in cash or, with respect to the portion of a Participant's Account invested in the Company Stock Fund, in kind at the Participant's election.

Section 5.02 Withdrawals of After–tax and Rollover Contributions. A Participant may elect to withdraw from either his After–tax Contribution Account or his Rollover Contribution Account at any time.

Section 5.03 Withdrawals of Matching Contributions and Profit Sharing Contributions.

A. Upon application, a Participant who has completed 60 months as a Participant may elect to receive a distribution of all or any portion of his Matching Contribution Account and/or Profit Sharing Account, including if applicable the Next Gen Employer Contribution Account.

For Matching Contributions and/or Profit Sharing Contributions (including Employer Contributions) allocated prior to July 1, 2009, if a Participant has not completed 60 months as a Participant on the first day of the Plan Year in which a withdrawal request is made under this Section, any withdrawal of amounts from the Participant's Matching Contribution Account and/or Profit Sharing Account (including the Next Gen Employer Contribution Account) pursuant to this Section shall be limited to the balance of such an Account derived from Matching

Contribution, Profit Sharing Contributions and Next Gen Employer Contributions in excess of such Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions allocated to his Account during the current Plan Year and the two Plan Years preceding the Plan Year in which the withdrawal takes place, adjusted for gains, earnings and losses attributable thereto. For Matching Contributions. Profit Sharing Contributions and Next Gen Employer Contributions allocated on or after July 1, 2009, a Participant shall not be permitted to withdraw such contributions if the Participant has not completed 60 months as a Participant as of the first day of the Plan Year in which the withdrawal request is made under this Section.

B. Withdrawals of Matching Contributions and/or Profit Sharing Contributions (including Next Gen Employer Contributions) under Subsection A above made prior to January 1, 2009 shall require a suspension of Participant deposits to the Plan for a period of six months. Withdrawals of such contributions on or after January 1, 2009 shall not require any suspension of Participant deposits to the Plan.

Section 5.04 Withdrawals at Age 59½. Upon application, a Participant may, upon written request to the Plan Administrator, make withdrawals of any amount up to his entire Account Balance on or after he has attained age 59 ½ .

Section 5.05 Hardship Withdrawals. Subject to any additional legal restrictions on in-service withdrawal rights (such as those outlined in Section 4.13), upon the application, a Participant may withdraw all or a portion of his entire Account (excluding, on or after January 1, 1989, all trust earnings credited to the Pre-tax Contributions Account, Roth Contribution Account or Catch-up Contribution Account) if the withdrawal is necessary due to the immediate and heavy financial need of the Participant.

A. Only distributions made pursuant to conditions arising under the following circumstances shall be conclusively considered to be made on account of immediate and heavy financial need:

(i) Alleviating extraordinary financial hardship arising from deductible medical expenses (within the meaning of Code Section 213(d)) previously incurred by the Participant or his Spouse, children, other dependents, or, effective as of August 17, 2006, Beneficiary, or necessary for such persons to obtain such care;

(ii) Purchasing real property (excluding mortgage payments) that is to serve as the principal residence of the Participant;

(iii) Expenditures necessary to prevent eviction from the Participant's principal residence or foreclosure of a mortgage on the same;

(iv) Financing the tuition and related educational fees for the next 12 months of post–secondary education for the Participant, his Spouse, his children, other dependents or, effective as of August 17, 2006, Beneficiary.

(v) payments for funeral or burial expenses for the employee's deceased parent, Spouse, child, dependent or, effective as of August 17, 2006, Beneficiary; or

(vi) expenses to repair damage to the employee's principal residence that would qualify for a casualty loss deduction under Code Section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income).

The last two financial needs specified in items (v) and (vi) above only apply to Plan Years beginning after 2005.

B. A distribution will be considered to be necessary to satisfy an immediate and heavy financial need of the Participant only if:

(i) The Participant has obtained all distributions other than hardship distributions, and all nontaxable loans, currently available under all plans maintained by the Employer, or by borrowing from commercial sources on reasonable commercial terms in an amount sufficient to satisfy the need;

(ii) The Participant has elected to receive any and all dividends attributable to the Participant's Account invested in the Company Stock Fund under Section 8.08.

(iii) All plans maintained by the Employer provide that the Participant's Pre–tax Contributions, Roth Contributions, Catch–up Contributions, or other Participant contributions will be suspended for 6 months after the receipt of the hardship distribution (which this Plan hereby so provides); and

(iv) The distribution is not in excess of the amount necessary to satisfy the immediate and heavy financial need, including any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution.

C. A Participant making an application under this Section 5.05 shall have the burden of presenting to the Plan Administrator evidence of such need, and the Plan Administrator shall not permit withdrawal under this Section without first receiving such evidence. If a Participant's application for a hardship withdrawal is approved, the Plan Administrator shall then instruct the Trustee to make payment of the approved amount of the hardship withdrawal to the Participant.

D. Notwithstanding the foregoing, in the event a Section 16(b) Officer requests a hardship distribution pursuant to this Section, any such distribution amount shall

not be available in whole or in part from the portion of the Participant's Account that is invested in the Company Stock Fund if restricted from transacting in Company stock by law or by the provisions of the Company's Securities Trading Policy. For purposes of this Section, "Section 16(b)" Officer shall mean an officer of the Company who is subject to the short-swing profit recapture rules of section 16(b) of the Securities Exchange Act of 1934, as amended.

Section 5.06 Withdrawals During Military Service.

A. Effective January 1, 2009, certain individuals performing military service shall have an additional in-service withdrawal right. Specifically, notwithstanding the definition of Compensation in Article I (stating in part that any Participant receiving differential wage payments shall be treated as an Employee) or any other provision herein to the contrary, for purposes of Code §401(k)(2)(B)(i)(I), and in accordance with Code §414(u)(12)(B), an individual shall be treated as having been severed from employment during any period the individual is performing service in the uniformed services (as defined in Chapter 43 of Title 38 of the United States Code) while on active duty for a period of more than 30 days. Accordingly, in accordance with Section 4.13, such Participant shall be eligible to take a distribution due to this considered Severance from Employment. However, the Plan will not distribute the benefit of such an individual without that individual's consent, so long as the individual is receiving differential wage payments.

B. Suspension of deferrals. If an individual elects to receive a distribution pursuant to this Section, the individual may not make an elective deferral or employee contribution during the 6-month period beginning on the date of the distribution.

Section 5.07 Direct Rollover and Withholding Rules.

A. Notwithstanding any provision of the Plan to the contrary that would otherwise limit a Distributee's election under this Section, a Distributee may elect, at the time and in the manner prescribed by the Plan Administrator, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover. The Plan Administrator may establish rules and procedures governing the processing of Direct Rollovers and limiting the amount or number of such Direct Rollovers in accordance with applicable Treasury Regulations. Distributions not transferred to an Eligible Retirement Plan in a Direct Rollover shall be subject to income tax withholding as provided under the Code and applicable state and local laws, if any.

B. Definitions.

(i) "Eligible Rollover Distribution." An Eligible Rollover Distribution is any distribution of all or any portion of the balance to the credit of the Distributee, except that an Eligible Rollover Distribution does not include: (a) any distribution that is one of a series of substantially equal

periodic payments (not less frequently than annually) made for life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and the Distributee's designated beneficiary, or for a specified period of ten years of more; (b) any distribution to the extent such distribution is required under Code Section 401(a)(9); and (c) any hardship distribution. Effective January 1, 2007, an Eligible Rollover Distribution shall also include any After-tax Contributions or Roth Contributions (effective January 1, 2010) if such rollover distribution is made by means of a direct rollover to a qualified plan or to a 403(b) plan that agrees to account separately for amounts so transferred, including accounting separately for the portion of such distribution which is includible in gross income and the portion of such distribution which is not includible in gross income.

(ii) "Eligible Retirement Plan." An Eligible Retirement Plan is an individual retirement account described in Code Section 408(a), an individual retirement annuity described in Code Section 408(b), an annuity plan described in Code Section 403(a), a qualified trust described in Code Section 401(a), a tax sheltered annuity plan described in Code Section 403(b) or an eligible deferred compensation plan described in Code Section 457(b) that is maintained by an eligible employer described in Code Section 457(e)(1)(A) which agrees to separately account for amounts transferred into such plan, that accepts the distributor's Eligible Rollover Distribution. The definition of "Eligible Retirement Plan" shall also apply in the case of a distribution to the employee's or former employee's surviving Spouse or the employee's or former employee's Spouse or former Spouse who is the alternate payee under a qualified domestic relations order, as defined in Code Section 414(p). Effective May 1, 2007, the definition of "Eligible Retirement Plan" also shall apply in the case of a distribution to an individual retirement account described in Code Section 408(a) or individual retirement annuity described in Code Section 408(b) established for the purpose of receiving such distribution on behalf of a non-spouse beneficiary of the Employee. For distributions made after December 31, 2007 to any Distributee (Participant or Beneficiary), an "Eligible Retirement Plan" shall include a Roth IRA described in Code Section 408A(b).

(iii) "Distributee." A Distributee includes an Employee or former Employee. In addition, the Employee's or former Employee's surviving Spouse and the Employee's or former Employee's Spouse or former Spouse who is the alternate payee under a qualified domestic relations order, as defined in Code Section 414(p), are Distributees with regard to the interest of the Spouse or former Spouse. Effective May 1, 2007, the Employee's non-spouse beneficiary also is a Distributee, but only for distributions to individual retirement accounts described in Code Section 408(a) or individual retirement annuities described in Code Section 408(b), as described in paragraph (ii) above.

(iv) "Direct Rollover." A Direct Rollover is a payment by the Plan to the Eligible Retirement Plan specified by the Distributee.

C. Special Rules Pertaining to Non–spouse Beneficiary Rollover Right. For distributions on or after May 1, 2007, a non–spouse beneficiary who is a "designated beneficiary" under Code Section 401(a)(9)(E) and the regulations thereunder, by a direct trustee–to–trustee transfer ("direct rollover"), may roll over all or any portion of his/her distribution to an individual retirement account the beneficiary establishes for purposes of receiving the distribution. In order to be able to roll over the distribution, the distribution otherwise must satisfy the definition of an Eligible Rollover Distribution.

(i) Certain requirements not applicable. Although a non–spouse beneficiary may roll over directly a distribution as provided in this Section 5.07, the distribution if made prior to January 1, 2010, is not subject to the direct rollover requirements of Code Section 401(a)(31), the notice requirements of Code Section 402(f) or the mandatory withholding requirements of Code Section 3405(c). If a non–spouse beneficiary receives a distribution from the Plan, the distribution is not eligible for a "60–day" rollover.

(ii) Trust Beneficiary. If the Participant's named beneficiary is a trust, the Plan may make a direct rollover to an individual retirement account on behalf of the trust, provided the trust satisfies the requirements to be a designated beneficiary within the meaning of Code Section 401(a)(9)(E).

(iii) Required Minimum Distributions Not Eligible for Rollover. A non–spouse beneficiary may not roll over an amount which is a required minimum distribution, as determined under applicable Treasury regulations and other Revenue Service guidance. If the Participant dies before his/her required beginning date and the non–spouse beneficiary rolls over to an IRA the maximum amount eligible for rollover, the beneficiary may elect to use either the 5–year rule or the life expectancy rule, pursuant to Treas. Reg. Section 1.401(a)(9)–3, A–4(c), in determining the required minimum distributions from the IRA that receives the non–spouse beneficiary's distribution

D. Special Rules Pertaining to Rollovers of Roth Contributions. Notwithstanding Section 5.07A above, a Direct Rollover of an Eligible Rollover Distribution from a Participant's Roth Contribution Account shall only be made to another Eligible Retirement Plan if such plan maintains a Roth elective deferral account thereunder and such plan is an "applicable retirement plan" as described in Code Section 402(A)(e)(1) or a Roth IRA described in Code Section 408A.

The Plan will accept a Rollover Contribution to the Roth Contribution Account on behalf of a Participant only if such Rollover Contribution is a Direct Rollover

from another Roth elective deferral account under an applicable retirement plan described in Section Code 402A(e)(1). Where such Direct Rollover of Roth elective deferrals from an applicable retirement plan is made, the period for determining whether distributions of such amounts are qualified distributions (as defined in Code Section 402A(d)(2)) shall be determined according to the rules under Code Section 402A(d)(2)(B).

Section 5.08 Loans to Participants. Loans may be granted to any Participant under the Plan in accordance with applicable rules under the Code and ERISA and the provisions of this Section.

A. General Rules. The Plan Administrator shall establish the procedures a Participant must follow to request a loan from his Account Balance under the Plan. Loans shall be made available to all Participants on a reasonably equivalent basis; provided, however, that loans will not be made available to a Former Participant, other than a Former Participant who is a Party–In–Interest as defined in Section 3(14) of ERISA whose Account has not been distributed.

In no event will the total of any outstanding loan balances made to any Participant, including any interest accrued thereon, when aggregated with corresponding loan balances of the Participant under any other plans of the Employer or any Related Employer, exceed the lesser of (i) or (ii), below:

(i) $50,000, reduced by the excess (if any) of the highest outstanding balance of such loans during the one–year period ending on the day before the date any such loan is made over the outstanding balance of such loans on the date any such loan is made; or

(ii) One–half of the value of the Participant's Account. For purposes of this Section, the value of a Participant's Account shall be determined as of the Valuation Date coinciding with or next preceding the date on which a properly completed loan request is received by the Plan Administrator (or its delegate) or the Trustee, as applicable.

The minimum amount of any loan shall be $1,000.

B. Term of Loan. The term of any loan shall be determined by mutual agreement between the Plan Administrator and the Participant. Every Participant who is granted a loan shall receive a statement of the charges and interest rates involved in each loan transaction and periodic statements reflecting the current loan balance and all transactions with respect to that loan to date. Except for loans used to acquire any dwelling unit that within a reasonable time (determined at the time the loan is made) is to be used as the principal residence of the Participant, the term of any loan shall not exceed five years. The term of any loan that within a reasonable time (determined at the time the loan is made) is to be used as the principal residence of the Participant shall not exceed 15 years. All loans shall be amortized in level payments made not less frequently than

quarterly over the term of the loan, or in accordance with other procedures established by the Plan Administrator.

C. Security. Each loan shall be secured by no more than one–half of the vested portion the Participant's nonforfeitable Account Balance (determined as of the Valuation Date coinciding with or next preceding the date on which the loan is made).

D. Interest. Each Participant loan shall be considered an investment of the Trust, and interest shall be charged thereon at a reasonable rate established by, or in accordance with procedures approved by, the Plan Administrator commensurate with the interest rates then being charged by persons in the business of lending money under similar circumstances. Notwithstanding the foregoing sentence, the Plan Administrator will reduce the interest rate of an outstanding Participant loan to 6% during a period of qualified military leave, as defined in Code Section 414(u)(5), to the extent required by the Soldiers' and Sailors' Civil Relief Act of 1940. Participant loans under this Section will be considered the directed investment of the Participant requesting such loan, and interest paid on such loan will be allocated to the Account of the Participant–borrower.

E. Party–In–Interest. The provisions of this Section shall apply to any Participant who is a Party–In–Interest (as defined in Section 3(14) of ERISA) and who retains an Account Balance in the Plan following termination of employment. Payments of principal and interest on a loan to any such Participant shall be made through direct debit from his bank account in accordance with the electronic loan payment procedures established by the Plan Administrator.

Such Participant's Account Balance, except for the portion secured by the loan (or loans), may at any time be distributed pursuant to the applicable terms of the Plan. Notwithstanding the preceding sentence, a loan to a Participant to whom this subsection E applies shall become payable in full on the date such Participant receives a final distribution of his Account Balance

F. Repayment Terms.

(i) Generally. The terms and conditions of each loan shall be determined by mutual agreement between the Plan Administrator and the Participant. The Plan Administrator shall take all necessary actions to ensure that each loan is repaid on schedule by its maturity date, including requiring repayment of the loan by payroll deduction. In the event a Participant (or his Beneficiary or Spouse) elects to receive a distribution from the Trust Fund at a time when there is an unpaid balance of a loan against such Participant's Account, the Trustee shall deduct the unpaid balance of the principal of such loan or any portion thereof, and any interest accrued to the date of such deduction, from any payment or distribution from the Trust Fund to which such Participant or his Beneficiary or Spouse may be entitled. If the amount of such payment or distribution is not

sufficient to repay the outstanding balance of such loan and any interest accrued thereon, the Participant (or his estate, if applicable) shall be liable for and continue to make payments on any balance still due from him.

(ii) Bank Debit. The provisions of this subsection F(ii) shall apply to any Participant who (a) terminates employment with all Employers on or after July 1, 2005, and (b) has an outstanding loan (or loans) as of his termination date. Payments of principal and interest on any such Participant's loan (or loans) may be made through direct debit from his bank account, in accordance with the electronic loan payment procedures established by the Plan Administrator. If any such Participant does not authorize payments through direct debit from his bank account, his outstanding loan shall be considered in default.

Except as set forth in subsection E, no Participant described in this subsection F(ii) shall be entitled to receive any new loan pursuant to this Section 5.08 from and after the date of his termination of employment. The balance of his Account, except for the portion secured by the loan (or loans), may be distributed pursuant to the applicable terms of the Plan. A loan to a Participant to whom this subsection F(ii) applies shall become payable in full on the date such Participant receives a final distribution of his Account Balance.

(iii) Suspension of Loan Payments during Disability Loan payments shall be suspended during a period of Disability of up to one year if the period of leave is unpaid or paid at a rate that does not accommodate a Participant's scheduled loan repayments. Following the Participant's return to employment after Disability or, if earlier, the expiration of the one-year period noted in the previous sentence, loan payments shall resume at an amount not less than that required by the terms of the original loan, and at a frequency such that the loan will be repaid in full during a period that is no longer than the "latest permissible term of the loan" (defined as the latest date permitted under Code Section 72(p)(2)(B). The latest permissible term of the loan determined under Code Section 72(p)(2)(B) shall not be extended due to the period of the Disability.

(iv) Suspension of Loan Payments during Qualified Military Leave. Loan payments shall be suspended during a period of "qualified military service," as defined in Code Section 414(u)(5). The duration of such period of service shall not be taken into account in determining the maximum permissible term of the loan under Code Section 72(p) and the regulations promulgated thereunder. Following the Participant's timely reemployment after a period of qualified military service, loan payments shall resume at an amount no less than required by the terms of the original loan, and at a frequency such that the loan will be repaid in full

during a period that is no longer than the "latest permissible term of the loan" (defined as latest date permitted under Code Section 72(p)(2)(B) plus the period of suspension due to such military service).

G. Restrictions on Loans. No Participant shall have more than two loans under this Section 5.08 outstanding at the same time. All loans will be paid by payroll deduction and a loan will be approved only if the Participant has sufficient income to support the required payroll withholdings.

H. Nondiscrimination. Loans will not be made available to Highly Compensated Employees in an amount greater than the amount made available to other Employees.

I. Default. Failure to make a payment within 90 days of the date payment is due will generally constitute a default, unless loan procedures and applicable law do not so require. Upon default (or, to the extent prohibited by law or by the terms of the Plan until a distributable event occurs, upon such event) the Plan Administrator will deduct the total unpaid amount of the loan and any unpaid interest due on the loan from the Participant's Account. The Plan Administrator may establish additional rules and procedures for handling loan defaults, including, but not limited to, restrictions on future borrowing.

J. Procedure. The Plan Administrator will establish nondiscriminatory policies and procedures to administer Participant loans.

Section 5.09 Special Withdrawal Rules Applicable to Transfer Accounts. Notwithstanding any other Plan provision to the contrary, if the Internal Revenue Service requires distribution to be made (or offered) with respect to any or all amounts held on behalf of a Participant with respect to a predecessor or transferor plan, as a condition of preserving the tax–qualified status of this Plan or of said predecessor or transferor plan, or if a court of competent jurisdiction issues an order or decree in respect of the Plan or its fiduciaries which is determined under relevant federal law to be enforceable, and which compels the distribution of a Participant's Plan interest, the Plan Administrator will be entitled to direct the prompt distribution (or offer of distribution) of such amounts.

ARTICLE VI

TESTING OF PRE–TAX, AFTER–TAX AND MATCHING CONTRIBUTIONS

Section 6.01 Definitions. For purposes of this Article, the following definitions shall apply:

A. "Actual Deferral Percentage" means the average of the actual deferral ratios (calculated separately for each Eligible Employee) of the amount of Pre–tax Contributions and Roth Contributions actually made by the Eligible Employee for such Plan Year to the Eligible Employee's Compensation for the period of time during such Plan Year that he participated in the Plan, rounded to the nearest one–hundredth of one percent.

B. "Actual Contribution Percentage" means the average of the actual contribution ratios (calculated separately for each Eligible Employee) of the amount of Matching Contributions actually made by an Employer for the Eligible Employee for such Plan Year, plus the amount of After–tax Contributions made by the Eligible Employee during such Plan Year, to such Employee's Compensation for the period of time during such Plan Year in which he participated in the Plan, rounded to the nearest one–hundredth of one percent.

C. "Eligible Employee" means any Participant in the Plan and any Employee who would be eligible to make Pre–tax Contributions, Roth Contributions or After–tax Contributions to the Plan for a Plan Year but for a suspension due to a distribution or a failure to elect to participate in the Plan.

D. "Excess Contributions" means, with respect to any Plan Year, the excess of the aggregate amount of the Pre–tax Contributions and Roth Contributions actually made on behalf of Highly Compensated Employees for such Plan Year over the maximum amount of such contributions permitted under the limitations of Code Section 401(k)(3)(A)(ii).

E. "Excess Aggregate Contributions" means, with respect to any Plan Year, the excess of the aggregate amount of the After–tax Contributions and Matching Contributions actually made on behalf of Highly Compensated Employees for such Plan Year over the maximum amount of such contributions permitted under the limitations of Code Section 401(m)(2)(A).

F. "Highly Compensated Eligible Employee" means an Eligible Employee who is a Highly Compensated Employee.

Section 6.02 Pre–tax and Roth Contributions: 401(k) Tests.

A. Actual Deferral Percentage Test. The total amount of Pre–tax Contributions and Roth Contributions shall comply with either (i) or (ii) below for each Plan Year:

(i) The Actual Deferral Percentage for the Highly Compensated Eligible Employees shall not exceed the Actual Deferral Percentage for all other Eligible Employees multiplied by 1.25; or

(ii) The Actual Deferral Percentage for Highly Compensated Eligible Employees shall not exceed the Actual Deferral Percentage of all other Eligible Employees multiplied by 2.0, provided that the Actual Deferral Percentage for the Highly Compensated Eligible Employees does not exceed that of all other Eligible Employees by more than two percentage points.

B. The Actual Deferral Percentage for the Plan Year for any Highly Compensated Eligible Employee who is eligible to make Pre-tax Contributions or Roth Contributions under two or more plans that are qualified under Code Section 401(a) or 401(k) and that are maintained by an Employer or a Related Employer must be determined as if all such deferrals were made under a single plan. Plans may be aggregated only if they have the same Plan Year.

C. In determining whether the requirements of Section 6.02A of the Plan are met, the Plan Administrator may aggregate plans on any basis as permitted under Code Section 401(a)(4) and Treasury Regulations thereunder.

D. Pre-tax Contributions and Roth Contributions shall be taken into account for purposes of determining the Actual Deferral Percentage of any Eligible Employee for a Plan Year only if such Pre-tax Contributions and Roth Contributions relate to Compensation that either (1) would have been received by the Eligible Employee in such Plan Year (but for the election to make such Pre-tax Contributions or Roth Contributions), or (2) is attributable to services performed by the Eligible Employee in such Plan Year and would have been received by the Eligible Employee within 2 ½ months after the end of such Plan Year (but for the election to make such Pre-tax Contributions or Roth Contributions).

E. Pre-tax Contributions and Roth Contributions shall be taken into account for purposes of determining the Actual Deferral Percentage of an Eligible Employee for a Plan Year only if such Pre-tax Contributions and Roth Contributions are allocated to the Pre-tax Contributions Account and Roth Contribution Account, as applicable, of the Eligible Employee as of a date that occurs within such Plan Year. For this purpose, Pre-tax Contributions and Roth Contributions are considered allocated as of a date within a Plan Year if the allocation is not contingent upon participation or performance of services after such date and the Pre-tax Contributions and Roth Contributions are actually paid to the Trustee no later than 12 months after the end of the Plan Year to which the Pre-tax Contributions and Roth Contributions relate.

F. The determination and treatment of the Actual Deferral Percentage of any Participant shall satisfy such other requirements as may be prescribed by the Secretary of the Treasury. In performing the required testing hereunder, any

variations in procedures or methods permitted under the Code and applicable Treasury Regulations may be employed

Section 6.03 Correction of Excess Contributions.

A. If the amount of Pre–tax Contributions and Roth Contributions made for Highly Compensated Eligible Employees in a Plan Year would not comply with either clause (i) or (ii) in Section 6.02A above, then the Plan Administrator in its discretion may choose either (i), (ii) or (iii) below, or any combination, in order to comply with such tests:

(i) In determining the Actual Deferral Percentage of Eligible Employees, the Plan Administrator may treat Matching Contributions, other than Matching Contributions used to meet the test in Section 6.04A, as Pre–tax Contributions; or

(ii) The Excess Contributions can, with the consent of the applicable Highly Compensated Eligible Employees, be recharacterized as After–tax Contributions solely for the purposes of Sections 6.02 and 6.04 of the Plan, within 2 ½ months after the related Plan Year, but only to the extent that it shall not cause the limitations in Section 6.04A to be exceeded, or

(iii) The Excess Contributions for such Plan Year (including the income, gains and losses attributable to such contributions as provided in B below) shall be distributed by the last day of the following twelve–month period to Highly Compensated Eligible Employees. Excess Contributions attributable to each Highly Compensated Eligible Employee shall be determined according to the following leveling method:

1. The Actual Deferral Percentage of the Highly Compensated Eligible Employee with the highest Actual Deferral Percentage for the Plan Year shall be reduced to the extent necessary to cause such Highly Compensated Eligible Employee's Actual Deferral Percentage to equal the Actual Deferral Percentage of the Highly Compensated Eligible Employee with the next highest Actual Deferral Percentage. This process shall be repeated until the Plan satisfies one of the tests set forth in Section 6.02 for such Plan Year.

2. The dollar amount of each prospective reduction made pursuant to (1) next above shall be determined for each Highly Compensated Eligible Employee and all such dollar amounts for such Plan Year shall be aggregated.

3. The total Pre–tax Contributions and, to the extent necessary, Roth Contributions of the Highly Compensated Eligible Employee with the highest dollar amount of total Pre–tax Contributions and Roth

Contributions for the Plan Year shall be reduced by the amount necessary to cause the amount of such Highly Compensated Eligible Employee's total Pre–tax Contributions and Roth Contributions to equal the total amount of Pre–tax Contributions and Roth Contributions of the Highly Compensated Eligible Employee with the next highest total dollar amount of Pre–tax Contributions and Roth Contributions for such Plan Year. This process shall be repeated until the total amount of Pre–tax Contributions and, to the extent necessary, Roth Contributions so reduced equals the aggregate dollar amount determined in (2) next above. For purposes of this leveling method, any necessary reductions for Highly Compensated Employees shall be first taken from Pre–tax Contributions to the extent necessary to complete the reductions under this subparagraph (3). Should such Pre–tax Contributions for a Plan Year for any affected Highly Compensated Employee be exhausted by this method, any remaining reduction required under this subparagraph (3) shall then be taken from Roth Contributions, if available, for the affected Highly Compensated Employees.

Following completion of this process, the amount of Excess Contributions for each Highly Compensated Eligible Employee shall be equal to the total of his Pre–tax Contributions and Roth Contributions reduced pursuant to the aforementioned leveling method.

In the event of the complete termination of the Plan during the Plan Year in which Excess Contributions arose, such distributions are to be made after termination of the Plan and before the close of the 12–month period that immediately follows such termination. Any distribution of Excess Contributions may be made without regard to any notice or consent requirements of the Plan.

B. The income, gains and losses allocable to Excess Contributions shall be the income, gains and losses attributable to such Excess Contributions for the Plan Year in which they occurred, determined pursuant to Code Section 401(k)(8). In addition, beginning with any Excess Contributions distributed on or after December 29, 2004, but not to include any Excess Contributions distributed after December 31, 2007, such income, gains and losses allocable to Excess Contributions shall include the income, gains and losses attributable to such Excess Contributions for the period commencing on the first day of the next Plan Year and ending on the date of distribution.

C. For purposes of this Section, a distribution occurring on or before the fifteenth day of the month shall be treated as having been made as of the last day of the preceding month and a distribution occurring after such fifteenth day shall be treated as having been made on the first day of the following month.

D. The amount of Excess Contributions to be distributed to, or recharacterized with respect to, a Highly Compensated Eligible Employee for a Plan Year shall be

reduced by any Excess Contributions previously distributed to the Highly Compensated Eligible Employee for the taxable year of the Highly Compensated Eligible Employee ending with or within the same Plan Year, and Excess Contributions to be distributed to a Highly Compensated Eligible Employee for a taxable year of the Highly Compensated Eligible Employee shall be reduced by Excess Contributions previously distributed, or recharacterized with respect to, such Highly Compensated Eligible Employee for the Plan Year beginning in such taxable year.

E. An amount of Matching Contributions attributable to the Pre–tax Contributions and, to the extent necessary, Roth Contributions distributed to a Highly Compensated Eligible Employee as an Excess Contribution pursuant to clause (iii) of Section 6.03A shall also be distributed to the applicable Highly Compensated Eligible Employee by the last day of the 12–month period following the end of the Plan Year in which such Excess Contributions occurred.

F. Excess Contributions that are recharacterized pursuant to clause (ii) Section 6.03A shall be nonforfeitable and fully vested and shall be subject to the distribution limitations set forth in Section 4.13 that are applicable to Pre–tax Contributions and Roth Contributions.

G. For purposes of this Section, the Actual Deferral Percentage for Highly Compensated Eligible Employees and for Eligible Employees who are not Highly Compensated Eligible Employees shall be determined for the current Plan Year.

Section 6.04 After–tax and Matching Contributions: 401(m) Tests.

A. Actual Contribution Percentage Test. The total amount of Matching Contributions as described in Section 3.04, except for any Matching Contributions used to satisfy the test in Section 6.02A, plus the total amount of After–tax Contributions as described under Section 3.02C, including any amount recharacterized as an After–tax Contribution under Section 6.03A(ii) above shall comply with either (i) or (ii) below for each Plan Year:

(i) The Actual Contribution Percentage for the Highly Compensated Eligible Employees shall not exceed the Actual Contribution Percentage for all other Eligible Employees multiplied by 1.25; or

(ii) The Actual Contribution Percentage for Highly Compensated Eligible Employees shall not exceed the Actual Contribution Percentage of all other Eligible Employees multiplied by 2.0, provided that the Actual Contribution Percentage for the Highly Compensated Eligible Employees does not exceed that of all other Eligible Employees by more than two percentage points.

B. The Actual Contribution Percentage for the Plan Year for any Highly Compensated Eligible Employee who is eligible to receive Matching Contributions or to make After–tax Contributions under two or more plans that

are qualified under Code Section 401(a) or 401(k) and that are maintained by an Employer or a Related Employer, must be determined as if all such contributions were made under a single plan. Plans may be aggregated only if they have the same Plan Year.

C. In determining whether the requirements in Section 6.04A are met, the Plan Administrator may aggregate plans as permitted under Code Section 401(a)(4) and Treasury Regulations thereunder.

D. The determination and treatment of the Actual Contribution Percentage of any Participant shall satisfy such other requirements as may be prescribed by the Secretary of the Treasury. In performing the required testing hereunder, any variations in procedures or methods permitted under the Code and applicable Treasury Regulations may be employed.

Section 6.05 Correction of Excess Aggregate Contributions.

A. If the amount of Matching Contributions plus After-tax Contributions made for Highly Compensated Eligible Employees in a Plan Year would not comply with either clause (i) or (ii) in Section 6.04A above, then the Plan Administrator in its discretion shall choose either (i) or (ii) below in order to comply with such tests:

(i) The Pre-tax Contributions and, to the extent necessary, Roth Contributions of nonhighly compensated Eligible Employees shall be recharacterized as Matching Contributions to the extent necessary to comply with either clause (i) or (ii) in Section 6.04A, provided that the Code Section 401(k) test for Pre-tax Contributions and Roth Contributions (as described in 6.02A(i) or (ii)) shall still be met both before and after such recharacterization; or

(ii) The Excess Aggregate Contributions for such Plan Year (including any income, gains or losses attributable to such contributions as provided in paragraph (b) below) shall be distributed by the last day of the following 12-month period to Highly Compensated Eligible Employees. Excess Aggregate Contributions attributable to each Highly Compensated Eligible Employee shall be determined according to the following leveling method:

1. The Actual Contribution Percentage of the Highly Compensated Eligible Employee with the highest Actual Contribution Percentage for the Plan Year shall be reduced to the extent necessary to cause such Highly Compensated Eligible Employee's Actual Contribution Percentage to equal the Actual Contribution Percentage of the Highly Compensated Eligible Employee with the next highest Actual Contribution Percentage for such Plan Year. This process shall be repeated until the Plan satisfies one of the tests set forth in Section 6.04 for such Plan Year.

2. The dollar amount of each reduction made pursuant to (1) next above shall be determined for each Highly Compensated Eligible Employee and all such dollar amounts for such Plan Year shall be aggregated.

3. The Matching Contributions and After–tax Contributions of the Highly Compensated Eligible Employee with the highest dollar amount of Matching Contributions and After–tax Contributions for the Plan Year shall be reduced to the extent necessary to cause the amount of such Highly Compensated Eligible Employee's Matching Contributions and After–tax Contributions to equal the amount of Matching Contributions and After–tax Contributions of the Highly Compensated Eligible Employee with the next highest dollar amount of Matching Contributions and After–tax Contributions. This process shall be repeated until the total amount of Matching Contributions and After–tax Contributions so reduced equals the aggregate dollar amount in (2) next above.

The amount of Excess Aggregate Contributions for a Plan Year shall be determined only after first determining the Excess Contributions that are recharacterized as After–tax Contributions pursuant to clause (ii) of Section 6.03A. The amount of Excess Aggregate Contributions to be distributed to each Highly Compensated Eligible Employee pursuant to this clause (ii) for a Plan Year shall be distributed on a pro rata basis from the After–tax Contributions made by such Highly Compensated Eligible Employee for such Plan Year and the Matching Contributions allocable to the Matching Contribution Account of the Highly Compensated Eligible Employee for such Plan Year.

In the event of the complete termination of the Plan during the Plan Year in which an Excess Aggregate Contribution arose, such distributions are to be made after termination of the Plan and before the close of the 12–month period that immediately follows such termination. Any distribution of Excess Aggregate Contributions may be made without regard to any notice or consent requirements of the Plan.

B. The income, gains and losses allocable to Excess Aggregate Contributions shall be such income, gains and losses attributable to such Excess Aggregate Contributions for the Plan Year in which they occurred, determined pursuant to Code Section 401(m)(6). In addition, beginning with any Excess Aggregate Contributions distributed on or after December 29, 2004, but not to include any Excess Aggregate Contributions distributed after December 31, 2007, such income, gains and losses allocable to Excess Aggregate Contributions shall include the income, gains and losses attributable to such Excess Aggregate Contributions for the period commencing on the first day of the next Plan Year and ending on the date of distribution.

C. For purposes of this Section 6.05, a distribution occurring on or before the fifteenth day of the month shall be treated as having been made as of the last day of the preceding month and a distribution occurring after such fifteenth day shall be treated as having been made on the first day of the following month.

D. For purposes of this Section 6.05, the Actual Contribution Percentage for Highly Compensated Eligible Employees and for Eligible Employees who are not Highly Compensated Eligible Employees shall be determined for the current Plan Year.

Section 6.06 Alternative to Distribution of Excess Amounts. In lieu of distributing Excess Contributions as provided in Section 6.03, or Excess Aggregate Contributions as provided in Section 6.05, and to the extent elected by the Plan Administrator, with respect either to all or some Employers or groups, the Employer may make "Qualified Non-elective Contributions" on behalf of Non-highly Compensated Employees (or all Employees) that are sufficient to satisfy either the Actual Deferral Percentage test or the Actual Contribution Percentage test, or both, pursuant to regulations under the Code, and in accordance with this Section.

For purposes of this Article, "Qualified Non-elective Contributions" shall mean contributions made by the Employer and allocated to Participants' Accounts that the Participants may not elect to receive in cash until distributed from the Plan; that are vested when made; and that are distributable only in accordance with the distribution provisions that are applicable to Pre-Tax Contributions. Qualified Non-elective Contributions shall be allocated to Participants' Accounts either (i) in the same proportion that each Participant's Compensation for the Plan Year for which the Employer makes the contribution bears to the total Compensation of all Participants for the Plan Year (or of all Non-highly Compensated Participants, as applicable) or (ii) in a flat dollar amount, as determined by the Plan Administrator. Qualified Non-elective Contributions may be made only with respect to eligible Participants within one or more Employers or divisions or with respect to all eligible Participants, as determined by the Plan Administrator.

ARTICLE VII

LIMITATIONS ON CONTRIBUTIONS AND BENEFITS

Section 7.01 Dollar Limitations on Pre-tax Contributions.

A. Code Section 402(g) Limitation. In no event shall the sum of (i) a Participant's Pre-tax Contributions for any calendar year (ii) a Participant's Roth Contributions and (iii) any other "elective deferrals" (as defined in Code Section 402(g)(3)) for any calendar year, exceed the dollar limitation set forth in Code Section 402(g) ($17,500 for 2014, $18,000 for 2015, and as adjusted thereafter), except to the extent Catch-up Contributions are permitted under Plan Section 3.02B and Code Section 414(v).

B. Distribution of Excess Deferrals. In the event that the aggregate amount of Pre-tax Contributions and Roth Contributions by a Participant exceeds the maximum dollar limitation as determined under subsection A above, the amount of such excess Pre-tax Contributions and Roth Contributions (the "Excess Elective Deferrals"), increased by any income and decreased by any losses attributable thereto, shall be returned to the Participant no later than April 15th of the calendar year following the calendar year for which the Pre-tax Contributions and Roth Contributions were made.

C. Determination of Income or Loss. Excess Elective Deferrals shall be adjusted for any income or loss for the calendar year in which such contributions occurred. Effective for the taxable year beginning January 1, 2007 and ending December 31, 2007, any refunds of Excess Elective Deferrals shall be adjusted for income or loss up to the date of distribution (the "Gap Period"). For taxable years beginning after December 31, 2007, adjustment for income or loss during the Gap Period shall not be required. The income or loss allocable to Excess Elective Deferrals is equal to the sum of the allocable gain or loss for the Plan Year and, to the extent that such Excess Elective Deferrals would otherwise be credited with gain or loss for the Gap Period if the total Account were to be distributed, the allocable gain or loss during that period.

The Plan Administrator may use any reasonable method for computing the income allocable to Excess Elective Deferrals, provided that the method does not violate Code Section 401(a)(4), is used consistently for all Participants and for all corrective distributions under the Plan for the Plan Year, and is used by the Plan for allocating income to Participants' Accounts. The Plan will not fail to use a reasonable method for computing the income allocable to Excess Elective Deferrals merely because the income allocable to such contributions is determined on a date that is no more than seven days before the actual distribution. In addition, the Plan Administrator may allocate income in any manner permitted under applicable Treasury Regulations.

Section 7.02 Annual Additions — Definitions. For purposes of Section 7.03, the following definitions and rules of interpretation shall apply:

A. "Annual Additions." The sum of the following amounts credited to a Participant's Account for any Limitation Year:

(i) Employer contributions;

(ii) Employee contributions (not including Catch–up Contributions); and

(iii) Forfeitures, if any.

Except to the extent provided in Treasury Regulations, Annual Additions also include any excess contributions described in Code Section 401(k), excess aggregate contributions described in Code Section 401(m), and excess deferrals described in Code Section 402(g), irrespective of whether the Plan distributes or forfeits such excess amounts. Annual Additions also include amounts allocated to an individual medical account (as defined in Code Section 415(l)(2)) included as part of a pension or annuity plan maintained by the Employer. Furthermore, Annual Additions include contributions attributable to post–retirement medical benefits allocated to the separate account of a Key Employee (as defined in Code Section 419(A)(d)(3)) under a welfare benefit fund (Code Section 419(e)) maintained by the Employer.

Annual Additions shall not include the following: (i) Transfer Contributions; (ii) Rollover Contributions; (iii) reinvestment of dividends pursuant to Section 8.08; and (iv) restorative payments allocated to a Participant's Account, which include payments made to restore losses to the Plan resulting from actions (or a failure to act) by a fiduciary for which there is a reasonable risk of liability under Title I of ERISA or under other applicable federal or state law, where similarly situated Participants are similarly treated.

B. "Excess Amount." For a Participant for each Limitation Year, the excess, if any of (i) the Annual Additions that would be credited to his Account under the terms of the Plan without regard to Code Section 415 over (ii) the maximum Annual Additions allowed under Code Section 415(c)(1)(A).

C. "Limitation Year." The Plan Year.

D. "Maximum Permissible Amount." The Maximum Permissible Amount with respect to any Participant shall be the lesser of:

(i) $52,000 for 2014 ($53,000 for 2015, and thereafter as adjusted for increases in cost–of–living under Code Section 415(d)), or

(ii) 100% of the Participant's Compensation for the Limitation Year.

The Compensation limit set forth in (ii) above, shall not apply to any contribution for medical benefits after separation from Service (within the meaning of Code Section 401(h) or Code Section 419(f)(2)), which is otherwise treated as an Annual Addition.

Section 7.03 Limitations Under Code Section 415. The amount of the Annual Addition that may be credited under the Plan to any Participant's Account, or that may be credited to such Participant under any other qualified plan, welfare benefit fund (as defined in Code Section 419(e)) or an individual medical account (as defined in Code Section 415(1)(2)), maintained by an Employer, for any Limitation Year shall not exceed the Maximum Permissible Amount.

The following provisions shall apply:

A. Notwithstanding anything contained in the Plan to the contrary, the provisions of the Plan shall at all times comply with the limitations, adjustments and other requirements prescribed in Code Section 415 and the Treasury Regulations thereunder, the terms of which are specifically incorporated herein by reference.

B. Subject to the provisions of subsection F, if the foregoing limitation on allocations would be exceeded in any Limitation Year for any Participant as a result of (i) reasonable error in estimating such Participant's Compensation, (ii) reasonable error in determining the amount of elective deferrals within the meaning of Code Section 402(g)(3) (that may be made with respect to such Participant) or (iii) under such other limited facts and circumstances that the Commissioner of Internal Revenue (pursuant to Treasury Regulation Section 415–6(b)(6)) finds justify the availability of this Section), the After–tax Contributions, Pre–tax Contributions and Roth Contributions made by or with respect to such Participant shall be distributed to him, to the extent that any such distribution would reduce the amount in excess of the limits of this Section. Any amount in excess of the limits of this Section remaining after such distribution shall be placed, unallocated to any Participant, in a designated Plan account ("Suspense Account.") If a Suspense Account is in existence at any time during a particular Limitation Year, other than the Limitation Year described in the preceding sentence, all amounts in the Suspense Account must be allocated to the Participants' Accounts (subject to the limits of this Section) before any contributions which would constitute Annual Additions may be made to the Plan for that Limitation Year. The excess amount allocated pursuant to this Section shall be used to reduce Matching Contributions for the next Limitation Year (and succeeding Limitation Years), as necessary, for that Participant. However, if that Participant is not covered by the Plan as of the end of the applicable Limitation Year, then the excess amounts must be held unallocated in the Suspense Account for the Limitation Year and allocated and reallocated in the next Limitation Year to all of the remaining Participants in the Plan. The Suspense Account shall not share in the valuation of Participants' Accounts, and the allocation of earnings set forth in Section 8.02 of the Plan and the change in fair market value and allocation of earnings attributable to the Suspense Account

shall be allocated to the remaining Accounts hereunder as set forth in Section 8.02.

C. Prior to determining a Participant's actual Compensation for the Limitation Year, the Plan Administrator may determine the Maximum Permissible Amount for a Participant on the basis of a reasonable estimate of the Participant's Compensation for the Limitation Year uniformly determined for all Participants similarly situated.

D. As soon as is administratively feasible after the end of the Limitation Year, the Maximum Permissible Amount for the Limitation Year shall be determined on the basis of the Participant's actual Compensation for the Limitation Year.

E. If pursuant to subsections B and D there is an Excess Amount to be distributed to a Participant covered by the Plan at the end of the Limitation Year, the excess shall be disposed of by the Plan Administrator as follows:

(i) After–tax Contributions, adjusted for earnings, gains and losses allocable thereto, shall be returned to the Participant, to the extent they would reduce the Excess Amount.

(ii) If, after the application of paragraph (i), an Excess Amount still exists, Pre–tax Contributions, adjusted for earnings, gains and losses allocable thereto, shall be returned to the Participant, to the extent they would reduce the Excess Amount.

(iii) If, after the application of paragraph (i) and (ii), an Excess Amount still exists, Roth Contributions, adjusted for earnings, gains and losses allocable thereto, shall be returned to the Participant, to the extent they would reduce the Excess Amount.

(iv) If, after the application of paragraphs (i), (ii) and (iii), an Excess Amount still exists, the Excess Amount in the Suspense Account shall be used to reduce Matching Contributions for such Participant in the next Limitation Year, and each succeeding Limitation Year, if necessary

F. Effective for any Limitation Year beginning on or after July 1, 2007, and anything herein to the contrary notwithstanding, if there is an Excess Amount to be distributed to a Participant covered by the Plan at the end of the Limitation Year, the Employer may only correct such excess in accordance with the Employee Plans Compliance Resolution System (EPCRS), or any successor thereto.

ARTICLE VIII

TRUST CREATION, ALLOCATION AND INVESTMENTS

Section 8.01 Establishment of Trust. On behalf of the Plan, an agreement has been executed (the "Trust Agreement") to establish a trust to hold the assets of the Plan (the "Trust") and to appoint one or more persons or parties who shall serve as the Trustee. The Trustee so selected shall serve as the Trustee until otherwise replaced by the Committee or said Trust Agreement is terminated. The Committee may, from time to time, enter into such further agreements with the Trustee or other parties and make such amendments to said Trust Agreement as it may deem necessary or desirable to carry out this Plan. Any and all rights or benefits which may accrue to a person under this Plan shall be subject to all the terms and provisions of the Trust Agreement.

Section 8.02 Accounting and Adjustments. With respect to each Participant, the Plan Administrator and Trustee may maintain separate subaccounts (for accounting purposes only) to reflect the different kinds of contributions made to the Plan, as follows: Pre–tax Contributions Account, Roth Contributions Account, Catch–up Contributions Account, After–tax Contribution Account, Matching Contribution Account, Profit Sharing Account, Next Gen Employer Contribution Account, Prior Profit Sharing Account, Rollover Account and Transfer Account(s), if any, and any additional subaccounts as needed.

Amounts credited to such subaccounts shall be allocated among the Participant's designated investments on a reasonable pro rata basis, in accordance with the valuation procedures of the Trustee and the Investment Funds. The Trustee and the Plan Administrator shall also establish uniform procedures which they may change from time to time, for the purpose of adjusting the subaccounts of a Participant's Account for withdrawals, loans, distributions and contributions. Gains, losses, withdrawals, distributions, forfeitures and other credits or charges may be separately allocated among such subaccounts on a reasonable and consistent basis in accordance with such procedures.

Section 8.03 Value of Participant's Account. The value of each Participant's Account shall be based on its fair market value on the appropriate Valuation Date. A valuation shall occur at least once every Plan Year, and otherwise in accordance with the terms of the Trust and administratively practicable procedures approved by the Plan Administrator. Periodically, on a frequency determined by the Plan Administrator and the Trustee, the Participant will receive a statement showing the transaction activity and value of his Account as of a date set forth in the statement.

Section 8.04 Investment Funds. The Committee and the Trustee shall establish certain investment funds (the "Investment Funds"), rules governing the administration of the Investment Funds, and procedures for directing the investment of Participant Accounts among the Investment Funds. The Trustee shall invest and reinvest the principal and income of each Account in the Trust Fund as required by ERISA and as directed by Participants. The Committee reserves the right to change the investment options available under the Plan and the rules governing investment designations at any time and from time to time.

Notwithstanding any other provisions of the Plan, assets of the Trust may be invested in any collective investment fund or funds, including common and group trust funds presently in existence or hereafter established. The assets so invested shall be subject to all the provisions of the instruments establishing such funds as they may be amended from time to time, and which are hereby incorporated by reference.

Section 8.05 Participant Direction of Investment. The Plan Administrator and the Trustee shall establish rules governing the administration of Investment Funds and procedures for Participant direction of investment, including rules governing the timing, frequency and manner of making investment elections. Nothing in this or any other provision of the Plan shall require the Trustee or the Plan Administrator to implement Participant investment directions or changes in such directions, or to establish any procedures, other than on an administratively practicable basis, as determined by the Committee in its discretion.

Each Participant shall, in accordance with procedures established by the Plan Administrator and the Trustee, direct that his Account and contributions thereto be invested and reinvested in any one or more of the Investment Funds. The investment of any such monies shall be subject to such restrictions as the Plan Administrator may determine, in its sole discretion, to be advisable or necessary under the circumstances. Moreover, in accordance with procedures established by the Trustee and agreed to by the Plan Administrator, Participants may, when administratively practicable, be permitted to change their current and prospective investment designations through telephone, "on–line" or similar instructions to the Trustee or its authorized agent on a frequency established under such procedures, as in effect from time to time.

The exercise of investment direction by a Participant will not cause the Participant to be a fiduciary solely by reason of such exercise, and neither the Trustee nor any other fiduciary of this Plan will be liable for any loss or any breach that results from the exercise of investment direction by the Participant. The investment designation procedures established under the Plan shall be and are intended to be in compliance with the requirements of ERISA Section 404(c) and the regulations thereunder.

Notwithstanding any provision to the contrary, the Committee may, in its sole discretion and where the terms of any relevant investment contracts, regulated investment companies or pooled or group trusts so require, impose special terms, conditions and restrictions upon a Participant's right to direct the investment in, or transfer into or out of, such contracts, companies or trusts.

Section 8.06 Administration of Investment Designations.

A. Affirmative Direction. The Trustees shall invest and reinvest the Account as the Participant shall instruct the Plan Administrator, according to the provisions of Section 8.05 by such means of instruction as provided by the Plan Administrator. The instructions of a Participant shall remain in force until altered by him. With the exception of automatic Pre–tax Contributions, no contributions may be authorized by or made for a Participant unless an investment instruction with respect to such contributions is provided by him prior to the date such contributions are authorized or delivered. A Participant shall not be allowed to

withdraw all prior investment instructions unless simultaneous therewith he delivers new investment instructions.

B. Default Investments. To the extent that a Participant fails to give the investment directions contemplated in subsection A above with respect to automatic Pre–tax Contributions, the Participant's Account related to such contributions shall be invested in such default investment fund(s) established by the Committee in its discretion. In addition, with respect to any Rollover Contributions for a Participant who fails to give the investment directions contemplated in subsection A above, the Participant's Account related to such contributions shall be invested in such default investment fund(s) established by the Committee in its discretions, which such fund(s) may or may not be the same fund(s) established for automatic Pre-Tax Contributions. In establishing such default investment fund(s), the Committee may elect to comply with the rules and regulations applicable to "qualified default investment alternatives" as established by the Department of Labor pursuant to Section 404(c)(5) of ERISA.

C. Changing Designations. Any investment election given by a Participant for investment of his Account shall continue in effect until changed by the Participant or Beneficiary. A Participant or Beneficiary may change his current investment election as to his future Account in accordance with procedures established by the Plan Administrator.

Section 8.07 Special Rules Pertaining to Investment of Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions. Except as provided in Schedule II, all Matching Contributions, Profit Sharing Contributions (whether made in the form of cash or Company Stock, pursuant to Section 3.08) and Next Gen Employer Contributions shall initially be invested in the Company Stock Fund. Thereafter, in accordance with the provisions of Section 8.05 and 8.06. a Participant may elect to change such investment designation to a different Investment Fund. Effective January 1, 2007, with respect to the Participant's ability change such investment designation, the following provisions shall apply: (1) the Plan shall offer not less than three different Investment Funds, other than the Company Stock Fund, to which the Participant may direct the proceeds of divestment of Company Stock, each of which options is diversified and has materially different risk and return characteristics; (2) the Plan shall provide reasonable divestment and reinvestment opportunities no less than quarterly; and (3) except as provided in regulations, the Plan shall not impose restrictions or conditions on the investment of Company Stock which the Plan does not impose on the investment of other Plan assets, other than restrictions or conditions imposed by reason of the application of securities laws or a condition permitted under IRS Notice 2006-107 or other applicable guidance.

Section 8.08 Special Rules Pertaining to the Company Stock Fund.

A. Dividends. Dividends attributable to a Participant's Account invested in the Company Stock Fund shall, at the election of the Participant, be payable to him in cash or reinvested in the Company Stock Fund. Such election shall be made no later than 15 days before the date on which such dividend is paid by the Company. Any Participant who fails to make a timely election shall have

dividends attributable to the investment of his Account in the Company Stock Fund reinvested in the Company Stock Fund. Notwithstanding the previous sentences, any dividend payment less than $10 shall be so reinvested.

B. Procedures for Voting.

(i) When the issuer of Company Stock files preliminary proxy solicitation materials with the Securities and Exchange Commission, the Company shall cause a summary of the items being voted upon to be simultaneously sent to the Trustee. Based on this summary the Trustee shall prepare a voting instruction form. At the time of mailing of the notice of each annual or special stockholders' meeting of the Company, the Company shall cause a copy of the notice and all proxy solicitation materials to be sent to each Participant, together with the foregoing voting instruction form to be returned to the Trustee or its designee. The form shall show the number of full and fractional shares of Company Stock credited to the Participant's Account. For purposes of this Section, the number of shares of Company Stock deemed "credited" to the Participant's Account, attributable to the Company Stock Fund, shall be determined as of the last preceding valuation date for which an allocation has been completed and Company Stock has actually been credited to Participants' Accounts. The Company shall provide the Trustee with a copy of any materials provided to the Participants and shall certify to the Trustee that the materials have been mailed or otherwise sent to Participants.

(ii) Each Participant shall have the right to direct the Trustee as to the manner in which the Trustee is to vote that number of shares of Company Stock credited to the Participant's Account. Directions from a Participant to the Trustee concerning the voting of Company Stock shall be communicated in writing, or by such other means as agreed upon by the Trustee and the Committee; these directions shall be held in confidence by the Trustee and shall not be divulged to the Company, or any officer or employee thereof, or any other person. Upon its receipt of the directions, the Trustee shall vote the shares of Company Stock as directed by the Participant. The Trustee shall not vote shares of Company Stock credited to a Participant's Account for which it has received no directions from the Participant. Notwithstanding the foregoing, effective November 1, 2011, the Trustee shall vote shares of Company Stock that are credited to a Participant's Account and for which it has received no directions from the Participant, in the same proportion as it votes those shares for which it has received voting direction from Participants.

(iii) The Trustee shall vote that number of shares of Company Stock not credited to Participants' Accounts, which is determined by multiplying the total number of shares not credited to Participants' Accounts by a

fraction, the numerator of which is the number of shares of Company Stock credited to Participants' Accounts for which the Trustee received voting directions from Participants and the denominator of which is the total number of shares of Company Stock credited to Participants' Accounts. The Trustee shall vote those shares of Company Stock not credited to Participants' Accounts which are to be voted by the Trustee pursuant to the foregoing formula in the same proportion on each issue as it votes those shares credited to Participants' Accounts for which it received voting directions from Participants. The Trustee shall not vote the remaining shares of Company Stock not credited to Participants' Accounts.

C. Procedures for Tendering.

(i) Upon commencement of a tender offer for any securities held in the Trust that are Company Stock, attributable to the Company Stock Fund, the Company shall notify each Participant of the tender offer and utilize its best efforts to timely distribute or cause to be distributed to the Participant the same information that is distributed to shareholders of the issuer of Company Stock in connection with the tender offer, and, after consulting with the Trustee, shall provide and pay for a means by which the Participant may direct the Trustee whether or not to tender the Company Stock credited to the Participant's Account. The Company shall provide the Trustee with a copy of any material provided to the Participants and shall certify to the Trustee that the materials have been mailed or otherwise sent to Participants.

(ii) Each Participant shall have the right to direct the Trustee to tender or not to tender some or all of the shares of Company Stock credited to the Participant's Account. Directions from a Participant to the Trustee concerning the tender of Company Stock shall be communicated in writing. The Trustee shall tender or not tender shares of Company Stock as directed by the Participant. The Trustee shall not tender shares of Company Stock credited to Participants' Accounts for which it has received no directions from the Participants. Directions received from Participants shall be held in confidence by the Trustee and shall not be divulged to the Company or any officer or employee thereof or any other person.

(iii) The Trustee shall tender that number of shares of Company Stock not credited to Participants' Accounts which is determined by multiplying the total number of shares of Company Stock not credited to Participants' Accounts by a fraction, the numerator of which is the number of shares of Company Stock credited to Participants' Accounts for which the Trustee has received directions from Participants to tender (which directions have not been withdrawn as of the date of this determination)

and the denominator of which is the total number of shares of Company Stock credited to Participants' Accounts.

(iv) A Participant who has directed the Trustee to tender some or all of the shares of Company Stock credited to the Participant's Account may, at any time prior to the tender offer withdrawal date, direct the Trustee to withdraw some or all of the tendered shares, and the Trustee shall withdraw the directed number of shares from the tender offer prior to the tender offer withdrawal deadline. Prior to the withdrawal deadline, if any shares of Company Stock not credited to Participants' Accounts have been tendered, the Trustee shall redetermine the number of shares of Company Stock that would be tendered if the date of the tender offer withdrawal were the date of determination, and withdraw from the tender offer the number of shares of Company Stock not credited to Participants' Accounts necessary to reduce the amount of tendered Company Stock not credited to Participants' Accounts to the amount so redetermined. A Participant shall not be limited as to the number of directions to tender or withdraw that the Participant may give to the Trustee.

(v) A direction by a Participant to the Trustee to tender shares of Company Stock credited to the Participant's Account shall not be considered a written election under the Plan by the Participant to withdraw, or have distributed, any or all of his withdrawable shares. The Trustee shall credit to each Participant's Account from which the tendered shares were taken the proceeds received by the Trustee in exchange for the shares of Company Stock tendered from that Account.

ARTICLE IX

PARTICIPANT ADMINISTRATIVE PROVISIONS

Section 9.01 Personal Data to Committee. Each Participant and each Beneficiary of a deceased Participant must furnish to the Plan Administrator such evidence, data or information as the Plan Administrator considers necessary or desirable for the purpose of administering the Plan. The provisions of this Plan are effective for the benefit of each Participant upon the condition precedent that each Participant will furnish promptly full, true and complete evidence, data and information when requested by the Plan Administrator, provided the Plan Administrator shall advise each Participant of the effect of his failure to comply with its request.

Section 9.02 Address For Notification. Each Participant and each Beneficiary of a deceased Participant shall file with the Plan Administrator, from time to time, in writing, or otherwise notify the Plan Administrator (in accordance with its rules and procedures) of, his post office address and any change of post office address. Any communication, statement or notice addressed to a Participant, or Beneficiary, at his last post office address filed with the Plan Administrator, or as shown on the records of the Employer, shall bind the Participant, or Beneficiary, for all purposes of this Plan.

Section 9.03 Assignment or Alienation. Subject to Code Section 414(p) relating to qualified domestic relations orders, neither a Participant nor a Beneficiary shall anticipate, assign or alienate (either at law or in equity) any benefit provided under the Plan, and the Trustee shall not recognize any such anticipation, assignment or alienation. Furthermore, a benefit under the Plan is not subject to attachment, garnishment, levy, execution or other legal or equitable process.

Section 9.04 Notice of Change in Terms. Within the time prescribed by ERISA and the applicable regulations, the Plan Administrator, on behalf of the Employer, shall furnish all Participants and Beneficiaries a summary description of any material amendment to the Plan or notice of discontinuance of the Plan and all other information required by ERISA to be furnished without charge.

Section 9.05 Litigation Against the Trust. If any legal action filed against the Trustee, the Plan Administrator, the Committee, or against any member or members of the Committee, by or on behalf of any Participant or Beneficiary, results adversely to the Participant or to the Beneficiary, the Trustee shall reimburse itself, the Plan Administrator, the Committee, or any member or members of the Committee, all costs and fees expended by it or them by surcharging all costs and fees against the sums payable under the Plan to the Participant or to the Beneficiary, but only to the extent a court of competent jurisdiction specifically authorizes and directs any such surcharges and only to the extent Code Section 401(a)(13) does not prohibit any such surcharges.

Section 9.06 Information Available. Any Participant in the Plan or any Beneficiary may examine copies of the Plan, the Trust, the Plan description, the latest annual report, any bargaining agreement, contract or any other instrument under which the Plan was established or

is operated. The Plan Administrator will maintain all of the items listed in this Section in the Company's offices, or in such other place or places as it may designate from time to time in order to comply with the regulations issued under ERISA, for examination during reasonable business hours. Upon the written request of a Participant or Beneficiary, the Employer shall furnish him with a copy of any item listed in this Section. The Employer may make a reasonable charge to the requesting person for the copy so furnished.

Section 9.07 Special Rules Relating to Veterans Reemployment Rights Under USERRA. The following special provisions of this Section shall apply to an Employee or Participant who is reemployed in accordance with the reemployment provisions of the Uniformed Services Employment and Reemployment Rights Act ("USERRA") following a period of qualifying military service (as determined under USERRA):

A. Each period of qualifying military service served by an Employee or Participant shall, upon such reemployment, be deemed to constitute service with an Employer for all purposes of the Plan.

B. The Participant shall be permitted to make up Pre-tax Contributions and Roth Contributions missed during the period of qualifying military service. The Participant shall have a period of time beginning on the date of the Participant's reemployment with an Employer following his period of qualifying military service and extending over the lesser of (1) the product of three and the Participant's period of qualifying military service, and (2) five years, to make up such missed Pre-tax Contributions and Roth Contributions.

C. If an Employer made any Matching Contributions, Profit Sharing Contributions or Next Gen Employer Contributions to the Plan during the period of qualifying military service, it shall make a Matching Contribution, Profit Sharing Contribution or Next Gen Employer Contribution, as applicable, on behalf of the Participant upon the Participant's reemployment following his period of qualifying military service, in the amount that would have been made on behalf of such Participant had the Participant been employed during the period of qualifying military service.

D. An Employer shall not (1) credit earnings to a Participant's Accounts with respect to any Pre-tax Contribution, Roth Contribution, Matching Contribution, Profit Sharing Contribution or Next Gen Employer Contribution before such contribution is actually made, or (2) make up any allocation of forfeitures, with respect to the period of qualifying military service.

E. For all purposes under the Plan, including an Employer's liability for making contributions on behalf of a reemployed Participant as described above, the Participant shall be treated as having received Compensation from an Employer based on the rate of Compensation the Participant would have received during the period of qualifying military service, or if that rate is not reasonably certain, on the basis of the Participant's average rate of Compensation during the 12-month period immediately preceding such period.

F. If the Participant makes a Pre-tax Contribution or Roth Contribution, or an Employer makes a Matching Contribution, Profit Sharing Contribution or Next Gen Employer Contribution in accordance with the foregoing provisions of this Section 9.07, such contributions shall not be subject to any otherwise applicable limitation under Code Sections 402(g), 404(a) or 415, and shall not be taken into account in applying such limitations to other Pre-tax, Roth, Matching, Profit Sharing or Next Gen Employer Contributions under the Plan, or any other plan, with respect to the year in which such contributions are made, and such contributions shall be subject to these limitations only with respect to the year to which such contributions relate and only in accordance with Treasury Regulations prescribed by the Internal Revenue Service; and

G. The Plan shall not be treated as failing to meet the requirements of Code Sections 401(a)(4), 401(a)(26), 401(m), 410(b), or 416 by reason of such contributions.

Section 9.08 Claims Procedure. Claims for benefits under the Plan shall be made in writing to the Committee (or its delegate). Benefits under the Plan shall be paid only if the Committee, in its discretion, decides that the Claimant is entitled to them. If the Committee wholly or partially denies a claim for benefits, the Committee (or its delegate) shall, within a reasonable period of time, but no later than 90 days after receiving the claim, notify the Participant or Beneficiary (the "Claimant") in writing of the denial of the claim. If the Committee (or its delegate) fails to notify the Claimant in writing of the denial of the claim within 90 days after the Committee receives it, the claim shall be deemed denied. A notice of denial shall be written in a manner calculated to be understood by the Claimant, and shall contain:

A. The specific reason or reasons for denial of the claim;

B. Specific references to the pertinent Plan provisions upon which the denial is based;

C. A description of any additional material or information necessary for the Claimant to perfect the claim, together with an explanation of why such material or information is necessary; and

D. An explanation of the Plan's review procedure.

Within 60 days of the receipt by the Claimant of the written notice of denial of the claim, or within 60 days after the claim is deemed denied as set forth above, if applicable, the Claimant may file a written request with the Committee that it conduct a full and fair review of the denial of the Claimant's claim for benefits, including the conducting of a hearing, if the Committee deems one necessary. In connection with the Claimant's appeal of the denial of his benefit, the Claimant may review pertinent documents and may submit issues and comments in writing. The Committee shall render a decision on the claim appeal promptly, but not later than 60 days after receiving the Claimant's request for review, unless, in the discretion of the Committee, special circumstances (such as the need to hold a hearing) require an extension of time for processing, in

which case the 60–day period may be extended to 120 days. The Committee shall notify the Claimant in writing of any such extension. Notwithstanding the foregoing, if the Committee's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Committee's final determination with respect to the applicant's application for review may be made within the period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii) in lieu of the 60-day period (120-day period if extended due to special circumstances) described above.

The decision upon review shall (1) include specific reasons for the decision, (2) be written in a manner calculated to be understood by the Claimant and (3) contain specific references to the pertinent Plan provisions upon which the decision is based. If the decision on review is not furnished within the time period set forth above, the claim shall be deemed denied on review.

If such final determination is favorable to the Claimant, it shall be binding and conclusive. If such final determination is adverse to such Claimant, it shall be binding and conclusive unless the applicant notifies the Committee within 90 days after the mailing or delivery to him by the Committee of its determination that he intends to institute legal proceedings challenging the determination of the Committee, and actually institutes such legal proceeding within 180 days after such mailing or delivery.

ARTICLE X

ADMINISTRATION OF THE PLAN

Section 10.01 Allocation of Responsibility Among Fiduciaries For Plan and Trust Administration. The fiduciaries shall have only those powers, duties, responsibilities and obligations as are specifically given to them under this Plan and the Trust. The Employers shall have the sole responsibility for making the contributions provided for under Article III. The Committee shall have the sole authority to appoint and remove the Trustee and to amend or terminate, in whole or in part, the Plan or the Trust. The Committee shall have the final responsibility for the administration of the Plan, which responsibility is specifically described in this Plan and the Trust. The Committee shall be the "plan administrator" and the 'named fiduciary" within the meaning of Title I of ERISA. In addition, the Committee shall have the specific delegated powers and duties described in the further provisions of this Article X and such further powers and duties as specified in the Committee charter. The Trustee shall have the sole responsibility for the administration of the Trust and the management of the assets held under the Trust, all as specifically provided in the Trust.

Each fiduciary warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of this Plan and the Trust, authorizing or providing for such direction, information or action. Furthermore, each fiduciary may rely upon any such direction, information or action of another fiduciary as being proper under this Plan and the Trust, and is not required under this Plan or the Trust to inquire into the propriety of any such direction, information or action. It is intended under this Plan and the Trust that each fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and the Trust and shall not be responsible for any act or failure to act of another fiduciary. No fiduciary guarantees the Trust Fund in any manner against investment loss or depreciation in asset value.

Section 10.02 Appointment of Committee. The NiSource Benefits Committee (the "Committee") has administrative and investment responsibilities with respect to the Plan. In accordance with the Committee charter, the Chief Executive officer of the Company (the "CEO") has the authority to appoint and remove members of the Committee. All usual and reasonable expenses of the Committee may be paid in whole or in part by the Company, and any expenses not paid by the Company shall be paid by the Trustee out of the principal or income of the Trust Fund. Any members of the Committee who are Employees shall not receive compensation with respect to their services for the Committee.

Section 10.03 Committee Procedures. The Committee may act at a meeting or in writing without a meeting, pursuant to the applicable Committee charter. The Committee may adopt such bylaws and regulations as it deems desirable for the conduct of its affairs. All decisions of the Committee shall be made by the vote of the majority of members or of a quorum of members, including actions in writing taken without a meeting. By appropriate action, the Committee may authorize one or more of its members to execute documents on its behalf, and the Trustee, upon written notification of such authorization, shall accept and rely upon such documents until notified in writing that such authorization has been revoked by the Committee.

Section 10.04 Other Committee Powers and Duties. The Committee shall have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the discretionary authority to perform the following powers and duties:

A. To construe and enforce the terms of the Plan and the rules and regulations it adopts, including the discretionary authority to interpret the Plan documents and documents related to the Plan's operation (including, but not limited to, issues of fact and questions of eligibility, benefits, status and rights of participants);

B. To adopt rules of procedure, uniform policies and regulations necessary for the proper and efficient administration of the Plan, provided the rules are not inconsistent with the terms of this Plan and the Trust;

C. To authorize and approve amendments to and restatements of the Plan;

D. To direct the Trustee with respect to the crediting and distribution of the Trust;

E. To review and render decisions respecting a claim for (or denial of a claim for) a benefit under the Plan, including judgment of the standard of proof required in any claim, subject to the requirements of applicable law and the Plan;

F. To furnish the Employer with information that the Employer may require for tax or other purposes;

G. To cause to be made all reports or other filing necessary to meet the reporting, disclosure and other filing requirements of the Code, ERISA and other applicable statutes, regulations and other authorities issued thereunder that are the responsibility of the Plan Administrator;

H. Act as the employer representatives or members on each committee having administrative and/or investment responsibilities with respect to any plan maintained by NiSource or its affiliates pursuant to a collective bargaining agreement;

I. To engage the service of agents whom it may deem advisable to assist it with the performance of its duties;

J. To engage the services of an Investment Manager or Investment Managers (as defined in ERISA Section 3(38)), each of whom shall have full power and authority to manage, acquire or dispose (or direct the Trustee with respect to acquisition or disposition) of any Plan asset under its control; and

K. As permitted by the Employee Plans Compliance Resolution System ("EPCRS") issued by the Internal Revenue Service ("IRS"), as in effect from time to time, (i) to voluntarily correct any Plan qualification failure, including, but not limited to failures involving Plan operation, impermissible discrimination in favor of highly compensated employees, the specific terms of the Plan document, or demographic failures; (ii) implement any correction methodology permitted

under EPCRS; and (iii) negotiate the terms of a compliance statement or a closing agreement proposed by the IRS with respect to correction of a plan qualification failure.

Section 10.05 Rules and Decisions. The Committee may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Committee shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Committee shall be entitled to rely upon information furnished by an Employee, Participant or Beneficiary, an Employer, the legal counsel of an Employer, or the Trustee. Any determination by the Committee shall presumptively be conclusive and binding on all persons. The regularly kept records of the Company shall be conclusive and binding upon all persons with respect to an Employee's date and length of employment, time and amount of Compensation and the manner of payment thereof, type and length of any absence from work, and all other matters contained therein relating to Employees.

Section 10.06 Application and Forms For Benefits. The Committee may require a Participant or Beneficiary to complete and file with the Committee an application for a benefit and all other forms approved by the Committee, and to furnish all pertinent information requested by the Committee. The Committee may rely upon all such information so furnished to it, including the Participant's or Beneficiary's current mailing address.

Section 10.07 Authorization of Benefit Payments. The Committee shall issue directions to the Trustee concerning all benefits that are to be paid from the Trust Fund pursuant to the provisions of the Plan, or establish other procedures on which the Trustee may act, and warrants that all such directions are in accordance with this Plan.

Section 10.08 Funding Policy. The Committee shall, from time to time, review all pertinent Employee information and Plan data in order to establish the funding policy of the Plan and to determine the appropriate methods of carrying out the Plan's objectives. The Committee shall communicate periodically, as it deems appropriate, to the Trustee and to any Plan Investment Manager, the Plan's short–term and long–term financial needs so that investment policy can be coordinated with Plan financial requirements.

Section 10.09 Fiduciary Duties. In performing their duties, all fiduciaries with respect to the Plan shall act solely in the interest of the Participants and their Beneficiaries, and:

A. For the exclusive purpose of providing benefits to the Participants and their Beneficiaries;

B. With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims;

C. To the extent a fiduciary possesses and exercises investment responsibilities, by diversifying the investments of the Trust Fund so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

D. In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with the provisions of Title I of ERISA.

Section 10.10 Allocation or Delegation of Duties and Responsibilities. In furtherance of their duties and responsibilities under the Plan, the Committee may, subject always to the requirements of Section 10.09:

A. Employ agents to carry out nonfiduciary responsibilities;

B. Employ agents to carry out fiduciary responsibilities (other than trustee responsibilities as defined in Section 405(c)(3) of ERISA);

C. Consult with counsel, who may be of counsel to the Company; and

D. Provide for the allocation of fiduciary responsibilities (other than trustee responsibilities as defined in Section 405(c)(3) of ERISA) between and among the members of the Committee.

Section 10.11 Procedure For the Allocation or Delegation of Fiduciary Duties. Any action described in subsections B or D of Section 10.10 may be taken by the Committee only in accordance with the following procedure:

A. Such action shall be taken by a majority of the Committee in a resolution approved by a majority of such Committee.

B. The vote cast by each member of the Committee for or against the adoption of such resolution shall be recorded and made a part of the written record of the Committee's proceedings.

C. Any delegation of fiduciary responsibilities or any allocation of fiduciary responsibilities among members of the Committee may be modified or rescinded by the Committee according to the procedure set forth in subsections A and B of this Section 10.11.

Section 10.12 Records and Reports. The Employer (or the Committee if so designated by the Employer) shall exercise such authority and responsibility as it deems appropriate in order to comply with ERISA and governmental regulations issued thereunder relating to records of Participant's Service and Account balances; notifications to Participants; annual registration with the Internal Revenue Service; and annual reports to the Department of Labor.

Section 10.13 Individual Statement. As determined by the Committee in its discretion, the Plan Administrator shall furnish to the Participant (or to the Beneficiary of a deceased Participant) an individual statement reflecting the condition of his Account. In addition, subject to the requirements of ERISA, the Plan Administrator shall provide to any Participant or Beneficiary of a deceased Participant who so requests in writing, a statement indicating the total value of his Account and the nonforfeitable portion of such Account, if any. The Plan Administrator shall also furnish a written statement to any Participant who terminates

employment during the Plan Year and is entitled to a deferred vested benefit under the Plan as of the end of the Plan Year, if no retirement benefits have been paid with respect to such Participant during the Plan year. No Participant, except a member of the Committee and its designees, shall have the right to inspect the records reflecting the Account of any other Participant.

Section 10.14 Fees and Expenses From Fund. The Trustee, other than the Company when serving as such, shall receive reasonable annual compensation as may be agreed upon from time to time between the Committee and the Trustee. The Trustee shall pay all expenses reasonably incurred by it or by the Employer(s), the Committee, or other professional advisers or administrators in the administration of the Plan from the Trust Fund unless the Employer(s) pay the expenses. The Committee shall not treat any fee or expense paid, directly or indirectly, by an Employer as an Employer contribution. No person who is receiving full pay from the Employer shall receive compensation for services from the Trust Fund. Brokerage commissions, transfer taxes, and other charges and expenses in connection with the purchase and sale of securities shall be charged to each Investment Fund and/or Participant's Account, as applicable. Fees related to investments subject to Participant direction, and other fees resulting from or attributable to expenses incurred in relation to a Participant or Beneficiary or his Account may be charged to his Account to the extent permitted under the Code and ERISA.

The Trustee or other service provider may provide refunds of expenses, rebates or other similar revenue sharing credits on behalf of the Plan that relate to the assets of the Plan. At the Plan Administrator's sole discretion, such amounts paid by the Trustee or other service provider on behalf of the Plan may be used to pay reasonable administrative expenses of the Plan, or may be allocated to Participants in reasonable and nondiscriminatory manner, or in any combination of these solely to the extent permitted by applicable law.

Section 10.15 Use of Alternative Media. The Plan Administrator may include in any process or procedure for administering the Plan, the use of alternative media, including, but not limited to, telephonic, facsimile, computer or other such electronic means as available. Use of such alternative media shall be deemed to satisfy any Plan provision requiring a "written" document or an instrument to be signed "in writing" to the extent permissible under the Code, ERISA and applicable regulations.

Section 10.16 Information to Plan Administrator. Each Employer shall supply current information to the Plan Administrator as to the name, date of birth, date of employment, annual compensation, leaves of absence, Service, and date of termination of employment of each Employee who is, or who will be eligible to become, a Participant under the Plan, together with any other information that the Committee considers necessary. The Employer's records as to the current information that the Employer furnishes to the Committee shall be conclusive as to all persons.

Section 10.17 Limitation of Liability. Notwithstanding any other provision of the Plan or the Trust, no Employer nor member of the Committee, nor an individual acting as an employee or agent of any of them, shall be liable to any Participant or former Participant, or any Beneficiary or Spouse of any Participant or former Participant, for any claim, loss, liability,

or expense incurred in connection with the Plan or the Trust, except when the same shall have been judicially determined to be due to the willful misconduct of such person.

Section 10.18 Indemnity. The Company shall indemnify and hold harmless each member of the Committee, or any employee of an Employer or any individual acting as an employee or agent of any of them or of an Employer (to the extent not indemnified or saved harmless under any liability insurance or any other indemnification arrangement with respect to the Plan or the Trust) from any and all claims, losses, liabilities, costs, and expenses (including attorneys' fees) arising out of any actual or alleged act or failure to act with respect to the administration of the Plan or the Trust, except that no indemnification or defense shall be provided to any person with respect to any conduct that has been judicially determined, or agreed by the parties, to have constituted willful misconduct on the part of such person, or to have resulted in his receipt of personal profit or advantage to which he is not entitled. In connection with the indemnification provided by the preceding sentence, expenses incurred in defending a civil or criminal action, suit or proceeding, or incurred in connection with a civil or criminal investigation may be paid by the Company in advance of the final disposition of such action, suit, proceeding, or investigation, as authorized by the Committee in the specific case, upon receipt of an undertaking by or on behalf of the party to be indemnified to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Company pursuant to this paragraph.

Section 10.19 Severability. Each of the Sections contained in the Plan, and each provision in each Section, shall be enforceable independently of every other Section or provision in the Plan, and the invalidity or unenforceability of any Section or provision shall not invalidate or render unenforceable any other Section or provision contained herein. If any Section or provision in a Section is found invalid or unenforceable, it is the intent of the parties that a court of competent jurisdiction shall reform the Section or provision to produce its nearest enforceable economic equivalent.

Section 10.20 Recovery of Overpaid Benefits. If a payment of benefits to a Participant, Beneficiary or other individual entitled to payment under the Plan (such as an alternate payee pursuant to Section 4.10) (collectively, the "Recipient") exceeds the amount provided for under the terms of the Plan, either by mistake or for any other reason, the Plan Administrator shall have the authority to seek reimbursement of such overpaid benefits from the Recipient (plus interest calculated in accordance with guidance set forth by the Internal Revenue Service). If a Recipient is receiving benefit payments at the time an overpayment of prior benefits is discovered, the Plan Administrator shall have the authority to reduce such Recipient's benefit payments going forward in an amount as necessary in the Plan Administrator's discretion to recover the overpaid benefits.

Section 10.21 Forfeitures. To the extent permitted by applicable law, forfeitures may be used at the Plan Administrator's sole discretion to pay reasonable administrative expenses and/or to reduce Employer contributions.

ARTICLE XI

TOP HEAVY RULES

Section 11.01 Minimum Employer Contribution. If this Plan is "Top Heavy," as defined below, in any Plan Year, the Plan guarantees a minimum contribution (subject to the provisions of this Article XI) of three percent of Compensation for each "Non-Key Employee," as defined below, who is a Participant employed by the Employer on the Accounting Date of the Plan Year without regard to hours of Service completed during the Plan Year or to whether he has elected to make Pre-tax Contributions or Roth Contributions under Section 3.02, and who is not a Participant in a Top Heavy defined benefit plan maintained by the Employer. Participants who also participate in a Top Heavy defined benefit plan of the Employer shall receive the required minimum benefit in the defined benefit plan rather than in this Plan. The Plan satisfies the guaranteed minimum contribution for the Non-Key Employee if the Non-Key Employee's contribution rate is at least equal to the minimum contribution. For purposes of this paragraph, a Non-Key Employee Participant includes any Employee otherwise eligible to participate in the Plan but who is not a Participant because his Compensation does not exceed a specified level.

If the contribution rate for the "Key Employee," as defined below, with the highest contribution rate is less than three percent, the guaranteed minimum contribution for Non-Key Employees shall equal the highest contribution rate received by a Key Employee. The contribution rate is the sum of Employer contributions (not including Employer contributions to Social Security) and forfeitures allocated to the Participant's Account for the Plan Year divided by his "Compensation," as defined below, not in excess of the compensation limitation under Code Section 401(a)(17) for the Plan Year. For purposes of determining the minimum contribution for a Plan Year, the Plan Administrator shall consider contributions made to any plan pursuant to a compensation reduction agreement or similar arrangement as Employer contributions. To determine the contribution rate, the Plan Administrator shall consider all qualified Top Heavy defined contribution plans maintained by the Employer as a single plan.

Notwithstanding the preceding provisions of this Section 11.01, if a defined benefit plan maintained by the Employer that benefits a Key Employee depends on this Plan to satisfy the anti-discrimination rules of Code Section 401(a)(4) or the coverage rules of Code Section 410 (or another plan benefiting the Key Employee so depends on such defined benefit plan), the guaranteed minimum contribution for a Non-Key Employee is three percent of his Compensation regardless of the contribution rate for the Key Employees.

The minimum employer contribution required (to the extent required to be nonforfeitable under Code Section 416(b)) may not be forfeited under Code Section 411(a)(3)(B) or 411(a)(3)(D).

Section 11.02 Additional Contribution. If the contribution rate (excluding Pre-tax Contributions and Roth Contributions) for the Plan Year with respect to a Non-Key Employee described in Section 11.01 is less than the minimum contribution, the Employer will increase its contribution for such Employee to the extent necessary so his contribution rate for the Plan Year will equal the guaranteed minimum contribution. Matching Contributions will be taken

into account to satisfy the minimum contribution requirement under the Plan, or if the Plan provides that the minimum contribution requirement shall be met in another plan, such other plan. Matching Contributions that are used to satisfy the minimum contribution requirements shall be treated as matching contributions for purposes of the actual contribution percentage test and other requirements of Code Section 401(m). The additional contribution shall be allocated to the Account of a Non–Key Employee for whom the Employer makes the contribution.

Section 11.03 Determination of Top Heavy Status. The Plan is "Top Heavy" for a Plan Year if the Top Heavy ratio as of the Determination Date exceeds sixty percent (60%). The Top Heavy ratio is a fraction, the numerator of which is the sum of the present value of the Accounts of all Key Employees as of the Determination Date, and the denominator of which is a similar sum determined for all Employees. For purposes of determining the present value of the Accounts for the foregoing fraction, the Plan Administrator shall include contributions due as of the Determination Date and distributions made for any purpose within the one–year period ending on the Determination Date. In addition, the Plan Administrator shall also include distributions made within the five–year period ending on the Determination Date if such distributions were made for reasons other than upon severance from employment, death or disability (*e.g.*, in–service withdrawals); provided, however, that no distribution shall be counted more than once. In addition, the Plan Administrator shall calculate the Top Heavy ratio by disregarding the Account (including distributions, if any, of the Account balance) of an individual who has not received credit for at least one Hour of Service with the Employer during the one–year period ending on the Determination Date in such calculation. The Top Heavy ratio, including the extent to which it must take into account distributions, rollovers and transfers, shall be calculated in accordance with Code Section 416 and the Treasury Regulations thereunder.

If the Employer maintains other qualified plans (including a simplified employee pension plan), this Plan is Top Heavy only if it is part of the Required Aggregation Group, and the Top Heavy ratio for both the Required Aggregation Group and the Permissive Aggregation Group exceeds 60%. The Top Heavy ratio shall be calculated in the same manner as required by the first paragraph of this Section 11.03, taking into account all plans within the Aggregation Group. To the extent distributions to a Participant must be taken into account, the Plan Administrator shall include distributions from a terminated plan that would have been part of the Required Aggregation Group if it were in existence on the Determination Date. The present value of accrued benefits and the other amounts the Plan Administrator must take into account, under defined benefit plans or simplified employee pension plans included within the group, shall be calculated in accordance with the terms of those plans, Code Section 416 and the Treasury Regulations thereunder. If an aggregated plan does not have a valuation date coinciding with the Determination Date, the Plan Administrator shall value the accrued benefits or Accounts in the aggregated plan as of the most recent valuation date falling within the 12–month period ending on the Determination Date. The Plan Administrator shall calculate the Top Heavy ratio with reference to the Determination Dates that fall within the same calendar year.

The accrued benefit of a Participant other than a Key Employee shall be determined under (a) the method, if any, that uniformly applies for accrual purposes under all defined benefit plans maintained by the Employer, or (b) if there is no such method, as if such benefit accrued

not more rapidly than the slowest accrual rate permitted under the fractional rule of Code Section 411(b)(1)(C).

Code Section 416(g)(4)(H) as clarified by Revenue Ruling 2004-13 excludes from the definition of Top Heavy plan those plans that make only contributions described in Code Sections 401(k)(12) or 401(m)(11) for any Plan Year. If any other contributions are made (e.g., profit sharing contributions or forfeitures) for a Plan Year, the requirements of Code Section 416(g)(4)(H) are not met and the Plan is subject to the Top Heavy rules in Code Section 416 for that Plan Year.

Section 11.04 Top Heavy Vesting Schedule. For any Plan Year for which the Plan is Top Heavy, as determined in accordance with this Article XI, any Participant who severs from the employment of all Employers and all Affiliates shall have, as of the date thereof, a vested right to his entire Account Balance.

Section 11.05 Definitions. For purposes of applying the provisions of this Article XI:

A. "Key Employee" means any Employee or former Employee (including any deceased Employee) who at any time during the Plan Year that includes the Determination Date was (i) an officer of the Employer having annual Compensation greater than $170,000 (as adjusted under Code Section 416(i)(l)), (ii) a more than five-percent owner of the Employer, or (iii) a more than one-percent owner of the Employer having annual Compensation of more than $170,000. The Plan Administrator shall make the determination of who is a Key Employee in accordance with Code Section 416(i) and the Treasury Regulations promulgated thereunder.

B. "Non-Key Employee" is an Employee who does not meet the definition of Key Employee.

C. "Compensation" shall mean the first $260,000 for 2014 (and $265,000 for 2015 or such larger amount as the Commissioner of Internal Revenue may thereafter prescribe in accordance with Code Section 401(a)(17)) of Compensation as defined in Code Section 415(c)(3), but including amounts contributed by the Employer pursuant to a salary reduction agreement that are excludible from the Employee's gross income under Section 125, "deemed compensation" under Code Section 125, Section 132(f)(4), Section 402(a)(8), Section 402(h) or Section 403(b) of the Code.

D. "Required Aggregation Group" means:

(i) Each qualified plan of the Employer in which at least one Key Employee participates at any time during the five Plan Year period ending on the Determination Date; and

(ii) Any other qualified plan of the Employer that enables a plan described in (i) to meet the requirements of Code Section 401(a)(4) or Code Section 410.

The Required Aggregation Group includes any plan of the Employer which was maintained within the last five years ending on the Determination Date on which a top heaviness determination is being made if such plan would otherwise be part of the Required Aggregation Group for the Plan Year but for the fact it has been terminated.

E. "Permissive Aggregation Group" is the Required Aggregation Group plus any other qualified plans maintained by the Employer, but only if such group would satisfy in the aggregate the requirements of Code Section 401(a)(4) and Code Section 410. The Plan Administrator shall determine which plans to take into account in determining the Permissive Aggregation Group.

F. "Employer" shall mean all the members of a controlled group of corporations (as defined in Code Section 414(b)), of a commonly controlled group of trades or businesses (whether or not incorporated) (as defined in Code Section 414(c)), or an affiliated service group (as defined in Code Section 414(m)), of which the Employer is a part. However, the Plan Administrator shall not aggregate ownership interests in more than one member of a related group to determine whether an individual is a Key Employee because of his ownership interest in the Employer.

G. "Determination Date" for any Plan Year is the Accounting Date of the preceding Plan Year or, in the case of the first Plan Year of the Plan, the Accounting Date of that Plan Year.

ARTICLE XII

MISCELLANEOUS

Section 12.01 Evidence. Anyone required to give evidence under the terms of the Plan may do so by certificate, affidavit, document or other information that the person to act in reliance may consider pertinent, reliable and genuine, and to have been signed, made or presented by the proper party or parties. Both the Committee and the Trustee shall be fully protected in acting and relying upon any evidence described under the immediately preceding sentence.

Section 12.02 No Responsibility For Employer Action. Neither the Trustee nor the Committee shall have any obligation or responsibility with respect to any action required by the Plan to be taken by the Employer, any Participant or Eligible Employee, nor for the failure of any of the above persons to act or make any payment or contribution, or otherwise to provide any benefit contemplated under this Plan, nor shall the Trustee or the Committee be required to collect any contribution required under the Plan, or determine the correctness of the amount of any Employer contribution. Neither the Trustee nor the Committee need inquire into or be responsible for any action or failure to act on the part of the others. Any action required of a corporate Employer shall be by its Board or its designee.

Section 12.03 Fiduciaries Not Insurers. The Trustee, the Committee, the Plan Administrator and the Employer in no way guarantee the Trust Fund from loss or depreciation. The Employer does not guarantee the payment of any money that may be or becomes due to any person from the Trust Fund. The liability of the Committee, the Plan Administrator and the Trustee to make any payment from the Trust Fund at any time and all times is limited to the then available assets of the Trust.

Section 12.04 Waiver of Notice. Any person entitled to notice under the Plan may waive the notice, unless the Code or Treasury Regulations require the notice, or ERISA specifically or impliedly prohibits such a waiver.

Section 12.05 Successors. The Plan shall be binding upon all persons entitled to benefits under the Plan, their respective heirs and legal representatives, upon the Employer, its successors and assigns, and upon the Trustee, the Committee, the Plan Administrator and their successors.

Section 12.06 Word Usage. Words used in the masculine shall apply to the feminine where applicable, and wherever the context of the Plan dictates, the plural shall be read as singular and the singular as the plural.

Section 12.07 Headings. The headings are for reference only. In the event of a conflict between a heading and the content of a section, the content of the section shall control.

Section 12.08 Governing Law and Venue. In order to benefit Plan Participants by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section shall apply. Indiana law shall determine all questions arising with respect to the provisions of the Plan, except to the extent superseded by federal law. Any suit,

action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana and of the United States for the Northern District of Indiana. The Company, each Related Employer that adopts the Plan, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

Section 12.09 Employment Not Guaranteed. Nothing contained in this Plan, and nothing with respect to the establishment of the Trust, any modification or amendment to the Plan or the Trust, the creation of any Account, or the payment of any benefit, shall give any Employee, Employee–Participant or Beneficiary any right to continue employment, or any legal or equitable right against the Employer, or an Employee of the Employer, the Committee, the Trustee or its agents or employees, or the Plan Administrator. Nothing in the Plan shall be deemed or construed to impair or affect in any manner the right of the Employer, in its discretion, to hire Employees and, with or without cause, to discharge or terminate the service of Employees.

ARTICLE XIII

PLAN ADOPTION

Section 13.01 Adoption Procedure. With the written consent of the Committee, any Related Employer may adopt the Plan and the Trust for its eligible employees by appropriate resolution, that shall specify the effective date of such adoption and that may contain such changes and variations in Plan terms as the Committee approves. Any such adoption shall be contingent upon a determination by the Internal Revenue Service that such resolution, in conjunction with the Plan and with the Trust, constitutes a qualified plan and trust under applicable provisions. An Employer adopting the Plan shall compile and submit all information required by the Trustee with reference to its Eligible Employees.

Section 13.02 Joint Employers. If an Employee receives Compensation simultaneously from more than one participating Employer, the total amount of such Compensation shall be considered for the purposes of the Plan as having been paid by one participating Employer and the respective participating Employers shall share pro–ratably in contributions to the Plan on account of said Employee.

Section 13.03 Expenses. Each participating Employer shall pay such part of actuarial and other necessary expenses incurred in the administration of the Plan as the Trustee shall determine.

Section 13.04 Withdrawal. A participating Employer may withdraw from the Plan at any time by giving written notice of its intention to the Committee and the Trustee prior to the effective date of withdrawal; provided, however that such withdrawal may be subject to the provisions of Article XIV.

Section 13.05 Superseded Plans. If an Employer adopting the Plan already maintains a pension plan covering employees who shall be covered by the Plan, it may, with the consent of the Committee, provide in its resolution adopting the Plan for the merger, restatement and continuation, without discontinuance or termination, of its plan by the Plan.

ARTICLE XIV

EXCLUSIVE BENEFIT, AMENDMENT, TERMINATION

Section 14.01 Exclusive Benefit. Except as provided under Article III, the Employer shall have no beneficial interest in any asset of the Trust and no part of any asset in the Trust shall ever revert to or be repaid to the Employer, either directly or indirectly; nor prior to the satisfaction of all liabilities with respect to the Participants and their Beneficiaries under the Plan, shall any part of the corpus or income of the Trust Fund, or any asset of the Trust, be (at any time) used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Beneficiaries.

Section 14.02 Amendment By the Committee. The Committee shall have the right at any time and from time to time:

A. To amend this agreement in any manner it deems necessary or advisable in order to qualify (or maintain qualification of) this Plan and the Trust created under it under the appropriate provisions of the Code; and

B. To amend this agreement in any other manner.

However, no amendment shall authorize or permit any part of the Trust Fund (other than the part required to pay taxes and administration expenses) to be used for or diverted to purposes other than for the exclusive benefit of the Participants or their Beneficiaries or estates. No amendment shall cause or permit any portion of the Trust Fund to revert to or become a property of the Employer; and the Committee shall not make any amendment that affects the rights, duties or responsibilities of the Plan Administrator or the Committee without the written consent of the affected Plan Administrator or the affected member of the Committee. Furthermore, no amendment shall decrease a Participant's Account balance or accrued benefit or reduce or eliminate any benefit protected under Code Section 411(d)(6), with respect to a Participant with an Account balance or accrued benefit at the date of the amendment, except to the extent permitted under Code Section 412(c)(8).

The Committee shall make all amendments in writing. Each amendment shall state the date to which it is either retroactively or prospectively effective, and may be executed by any authorized member or other delegate of the Committee. Notwithstanding the foregoing, no oral representation shall act to amend the Plan in an manner or at any time.

Section 14.03 Discontinuance. The Committee shall have the right, at any time, to suspend or discontinue any Employer contributions under the Plan, or revoke the Employer's participation in the Plan. At the time of any such discontinuance or revocation, satisfactory evidence thereof and of any applicable conditions imposed shall be delivered to the Trustee. The Trustee shall thereafter transfer, deliver and assign Trust Fund assets allocable to the Participants employed by such Employer to such new trustee as shall have been designated by such Employer, in the event that it has established a separate pension plan for its Employees; provided however, that no such transfer shall be made if the result is the elimination or reduction of any benefit protected under Code Section 411(d)(6). If no successor is designated,

the Trustee shall retain such assets for the Employees of such Employer pursuant to the provisions of the Plan and Trust. In no such event shall any part of the corpus or income of the Trust as it relates to such Employer be used for or diverted to purposes other than for the exclusive benefit of the Employees of such Employer.

The Committee shall have the right to terminate, at any time, this Plan and the Trust created under this agreement. The Plan shall terminate upon the first to occur of the following:

A. The date terminated by action of the Committee.

B. The dissolution, merger, consolidation or reorganization of the Company or the sale by the Company of all or substantially all of its assets, unless the successor or purchaser makes provision to continue the Plan, in which event the successor or purchaser shall substitute itself as the Plan Sponsor under this Plan.

Section 14.04 Full Vesting on Termination. Notwithstanding any other provision of this Plan to the contrary, upon either full or partial termination of the Plan, or, if applicable, upon the date of complete discontinuance of contributions to the Plan, an affected Participant's right to his Account shall be 100% nonforfeitable.

Section 14.05 Merger, Direct Transfer and Elective Transfer. The Trustee shall not consent to, or be a party to, any merger or consolidation with another plan, or to a transfer of assets or liabilities to another plan, unless immediately after the merger, consolidation or transfer, the surviving plan provides each Participant a benefit equal to or greater than the benefit each Participant would have received had the Plan terminated immediately before the merger or consolidation or transfer. The Trustee possesses the specific authority to enter into merger agreements or direct transfer of assets agreements with the trustees of other retirement plans described in Code Section 401(a) and to accept the direct transfer of plan assets, or to transfer plan assets, as a party to any such agreement, only upon the consent or direction of the Committee.

If permitted by the Committee in its discretion, the Trustee may accept a direct transfer of plan assets on behalf of an Employee prior to the date the Employee satisfies the Plan's eligibility condition(s). If the Trustee accepts such a direct transfer of plan assets, the Committee and the Trustee shall treat the Employee as a Participant for all purposes of the Plan except that the Employee shall not share in Employer contributions or Participant forfeitures under the Plan until he actually becomes a Participant in the Plan. The Trustee shall hold, administer and distribute the transferred assets as a part of the Trust Fund, and the Trustee shall maintain a separate Transfer Account for the benefit of the Employee on whose behalf the Trustee accepted the transfer in order to reflect the value of the transferred assets.

The Trustee may not consent to, or be a party to, a merger, consolidation or transfer of assets with a defined benefit plan, except with respect to an elective transfer, unless the Committee consents and so directs, and the transfer is consistent with the Code and with ERISA. The Trustee will hold, administer and distribute the transferred assets as a part of the Trust Fund, and the Trustee shall maintain a separate Transfer Account for the benefit of the Employee on whose behalf the Trustee accepted the transfer in order to reflect the value of the transferred

assets. Unless a transfer of assets to this Plan is an elective transfer, the Plan will preserve all Code Section 411(d)(6) protected benefits with respect to those transferred assets, in the manner described in Section 14.02.

A transfer is an elective transfer if: (a) the transfer satisfies the first paragraph of this Section 14.05; (b) the transfer is voluntary, under a fully informed election by the Participant; (c) the Participant has an alternative that retains his Code Section 411(d)(6) protected benefits (including an option to leave his benefit in the transferor plan, if that plan is not terminating); (d) the transfer satisfies the applicable spousal consent requirements of the Code; (e) the transferor plan satisfies the joint and survivor notice requirements of the Code, if the Participant's transferred benefit is subject to those requirements; (f) the Participant has a right to immediate distribution from the transferor plan, in lieu of the elective transfer; (g) the transferred benefit is at least the greater of the single sum distribution provided by the transferor plan for which the Participant is eligible or the present value of the Participant's accrued benefit under the transferor plan payable at that plan's normal retirement age; (h) the Participant has a 100% nonforfeitable interest in the transferred benefit; and (i) the transfer otherwise satisfies applicable Treasury Regulations. An elective transfer may occur between qualified plans of any type.

If the Plan receives a direct transfer (by merger or otherwise) of elective contributions (or amounts treated as elective contributions) under a plan with a Code Section 401(k) arrangement, the distribution restrictions of Code Sections 401(k)(2) and (10) continue to apply to those transferred elective contributions.

Section 14.06 Termination. Upon a complete or partial termination of the Plan, the Accounts of all Participants affected thereby shall be fully vested, and the Committee may direct the Trustee:

A. to continue to administer the Trust Fund and pay Account Balances in accordance with Article IV to each Participant affected by the complete or partial termination upon his termination of employment or to his Beneficiary upon such Participant's death, until the Trust Fund, or the portion thereof applicable to the Participants affected by the partial termination, has been liquidated; or

B. to distribute the assets remaining in the Trust Fund, or the portion thereof attributable to Participants affected by the partial termination, after payment of any expenses properly chargeable thereto, to the applicable Participants and Beneficiaries in proportion to the respective Account Balances.

Section 14.07 Manner of Distribution. Upon termination of the Plan, distribution shall be made in cash or Company Stock in a manner consistent with the requirements of Article IV.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

IN WITNESS WHEREOF, this Amendment and Restatement of the NiSource Inc. Retirement Savings Plan is hereby executed on this 31st day of December, 2014, by the duly authorized representative of the NiSource Benefits Committee, to be effective as of January 1, 2014 or such other date as set forth in this Amendment and Restatement.

NISOURCE BENEFITS COMMITTEE

By: _____

Its: VP, HR

SCHEDULE I

MATCHING CONTRIBUTIONS

Subject to the limitations of Article VI and VII, an Employer shall contribute and pay or cause to be paid to the Trustee a Matching Contribution, as described in Section 3.05, determined as set forth in this Schedule I. The amount of Matching Contribution varies based on certain factors as described below, including (i) the kind of benefit a Participant is eligible to receive under the applicable plan of the NiSource Pension Plans, and (ii) the Participant's Employer.

Notwithstanding the following provisions of this Schedule I, with respect to Participants who were employed by Kokomo or NIFL as of June 30, 2011 and who transitioned to employment with NIPSCO on July 1, 2011, the Matching Contribution provisions applicable to such Kokomo or NIFL employees immediately prior to the merger shall remain in effect to the extent that pension plan provisions applicable to NIPSCO, NIFL, or Kokomo remain in effect. Effective December 31, 2012, the Subsidiary Pension Plan and the Kokomo Union Pension Plan merged into the NiSource Salaried Pension Plan and the NIPSCO Union Pension Plan (as applicable). However, the matching contribution provisions applicable to Kokomo or NIFL employees shall continue to be determined as immediately prior to the merger of the entities on July 1, 2011 as described above (except to the extent that any such employee changed pension benefit structures (e.g., switching from the AB II to the AB I Benefit structure)).

A. AB II Participants

For the Account of each Participant who participates in the AB II Benefit of any of the NiSource Pension Plans that offers such benefit, the Matching Contribution shall be an amount equal to 100% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

B. AB I Participants

For the Account of each Participant who participates in the AB I Benefit of any of the NiSource Pension Plans that offers such benefit, the Matching Contribution shall be an amount equal to 75% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

C. FAP Participants

(i) Columbia Participants. The provisions of this subparagraph (i) applied prior to January 1, 2013 (*i.e.*, the date that all Participants in the Columbia Pension Plan became uniformly subject to the AB II Benefit provisions). For the Account of each Participant employed by Columbia who participates in the FAP Benefit of the Columbia Pension Plan:

(a) during the first 120 months of the Participant's active participation in the Plan (*i.e.*, the period during which the Participant makes Participant Contributions pursuant to Section 3.02), the Matching Contribution shall be an amount equal to 50% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant;

(b) from the 121st through 240th month of the Participant's participation as defined above, the Matching Contribution shall be an amount equal to 75% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant; and

(c) from the 241st month of the Participant's participation as defined above onward, the Matching Contribution shall be an amount equal to 100% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

(ii) Bay State Participants (other than Bay State Union Employees). The provisions of this subparagraph (ii) applied prior to January 1, 2013 (*i.e.*, the date that all Participants in the Bay State Pension Plan became uniformly subject to the AB II Benefit provisions).

(a) On or After January 1, 2010. Effective as of January 1, 2010, for the Account of each Participant employed by Bay State who participates in the FAP Benefit of the Bay State Pension Plan, the Matching Contribution shall be an amount equal to 50% of the Pre–tax Contribution and Roth Contribution made by each Participant not to exceed 5% of the total Compensation of such Participant.

(b) Prior to January 1, 2010. Notwithstanding the foregoing, prior to January 1, 2010, the Matching Contribution described in subparagraph (a) above applied only for Participants employed by Bay State who were in the Final Pay Option of the Bay State Pension Plan and who were eligible for post-retirement medical benefits under the Bay State Pension Plan. If a Participant was not eligible for post-retirement medical benefits under the Bay State Pension Plan, the Matching Contribution prior to January 1, 2010 was an amount equal to 100% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 2.5% of the total Compensation of such Participant, and 50% of the Pre–tax Contribution and Roth Contribution made by each Participant on the next 5% of the total Compensation of such Participant.

(iii) NIFL Participants. For the Account of each Participant who was employed by NIFL immediately prior to the merger of NIFL with NIPSCO on July 1, 2011 who participated in the FAP Benefit of the former Subsidiary Pension Plan (merged into the NIPSCO Union Pension Plan effective as of December 31, 2012), the Matching Contribution shall be an amount equal to 50% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

(iv) Other FAP Participants. For the Account of each Participant employed by any Employer not covered in subsection C, paragraphs (i), (ii) or (iii) above, who participates in the FAP Benefit of the NiSource Salaried Pension Plan or the NIPSCO Union Pension Plan (including for purposes of this subsection (iv) employees of Kokomo immediately prior to the merger of Kokomo with NIPSCO on July 1, 2011 who participated in the Subsidiary Pension Plan or the Kokomo Union Pension Plan that merged into the NIPSCO Union Pension Plan effective December 31, 2012), the Matching Contribution shall be an amount equal to 11.1% of the Pre-tax Contribution and Roth Contribution made by or for such Participant.

D. Bay State Union Employees. For the Account of each Bay State Union Employee, the Matching Contribution shall be an amount as set forth in Schedule II.

E. NIPSCO Union Employees. In accordance with subsection B, above, for the Account of each NIPSCO Union Employee who participates in the AB 1 Benefit of the NIPSCO Union Pension Plan, the Matching Contribution amount shall be the amount described in such subsection B. In accordance with subsection C(iv), above, for the Account of each NIPSCO Union Employee who participates in the FAP Benefit of the NIPSCO Union Pension Plan (with the exception of any former NIFL employee as described in subsection C(iii) above), the Matching Contribution amount shall be the amount described in such subsection C(iv).

F. Next Gen Employees. Notwithstanding the foregoing, for any Eligible Employees who are or become Next Gen Employees, the Matching Contribution shall be an amount equal to 50% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

SCHEDULE II

SPECIAL PROVISIONS FOR BAY STATE UNION EMPLOYEES

Section II.01 BACKGROUND AND APPLICABILITY. Effective December 31, 2008 (the "Merger Date"), the Bay State Gas Company Savings Plan for Operating Employees ("Bay State Union 401(k) Plan") merged into the Plan and the assets of the Bay State Union 401(k) Plan transferred to the Plan. After the Merger Date, Bay State Union Employees participate in and are subject to the terms of the Plan and this Schedule II.

Section II.02 PLAN VS. SPECIAL PROVISIONS. Except as set forth in this Schedule II or as specifically otherwise provided elsewhere in the Plan, the provisions of the Plan shall apply to Bay State Union Employees. This Schedule II sets forth special provisions that shall apply solely to Bay State Union Employees.

Section II.03 ELIGIBILITY, PARTICIPATION AND ENROLLMENT

A. Eligible Employee. An Eligible Employee that is subject to one of the collective bargaining agreements set forth below shall be considered a Bay State Union Employee. (Such list is described in this Schedule II for informational purposes only and may be updated or modified as necessary by the Company.)

Bay State Collective Bargaining Units

- Lawrence Division, International Brotherhood of Electrical Workers, Local No. 326 ("*Lawrence Employees*")
- Brockton Division, Utility Workers' Union of America, AFL–CIO, Local No. 273 ("*Brockton Operating Employees*")
- Brockton Division, Utility Workers' Union of America, AFL–CIO, Local No. 273 Clerical/Technical Unit ("*Brockton C/T Employees*")
- Springfield Division, United Steelworkers of America, AFL–CIO, Local No. 12026 ("*Springfield Utility Employees*")
- Springfield Division, International Brotherhood of Electrical Workers, Local No. 486 ("*Northampton Employees*")
- Springfield Division, United Steelworkers of America, AFL–CIO–CLC, Local 12026 Clerical Technical Unit ("*Springfield C/T Employees*")

B. Participation and Enrollment Generally. In accordance with Plan Section 2.01, and except as provided in Section II.03C, below, a Bay State Union Employee shall become a Participant in the Plan on the first day of the month following the completion of a 60–day Period of Service and may enroll in the

Plan thereafter pursuant to the general enrollment provisions of Section 2.01A.

C. Participation and Enrollment Modifications, and Application of Automatic Enrollment for Specified Employees. Notwithstanding the provisions of Section II.03B above, the Bay State Union Employees set forth below shall both (i) become Participants upon their Employment Commencement Date (meaning that the 60-day Period of Service provision from Section II.03B above shall not apply) and (ii) be subject to the automatic enrollment provisions set forth in Section 2.01B of the Plan.

- Lawrence Employees hired or rehired on or after January 1, 2008.
- Brockton Operating Employees hired or rehired on or after January 1, 2008.
- Brockton C/T Employees hired or rehired on or after January 1, 2008.
- Northampton Employees hired or rehired on or after January 1, 2011.
- Springfield C/T Employees hired or rehired on or after January 1, 2011.
- Springfield Utility Employees hired or rehired on or after January 1, 2014.

The Automatic Percentage Amount for each such group of Bay State Union Employees shall be 3% of Compensation.

Section II.04 MATCHING CONTRIBUTIONS.

A. Amount. Subject to the limitations of Article VI and VII, and in accordance with Section 3.04 and subsection D of Schedule I, Bay State or the Company shall contribute and pay or cause to be paid to the Trustee a Matching Contribution, determined as set forth in this Section II.04A. The amount of such Matching Contribution shall be determined by the Bay State Union Employee's collective bargaining agreement as set forth below.

(i) Lawrence Employees and Brockton Operating Employees.

(a) In General. Effective January 1, 2013, Participants who are Lawrence Employees or Brockton Operating Employees are considered either Next Gen Employees or AB II Participants under the Bay State Union Plan and are subject to subparagraphs 1 or 2 below, as applicable.

1. Next Gen Employees. Each Lawrence Employee or Brockton Operating Employee hired or rehired on or after January 1, 2013 is considered a Next Gen Employee. Accordingly, as described in subsection F of Schedule I, each such Participant

shall be entitled to a Matching Contribution equal to 50% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

2. Employees Considered AB II Participants. Effective January 1, 2013, all Participants who are Lawrence or Brockton Operating Employees hired/rehired prior to January 1, 2013 (*i.e.*, not Next Gen Employees) are considered AB II Participants under the Bay State Union Plan. In accordance with the provisions of subsection A of Schedule I, each such Participant shall be entitled to a Matching Contribution equal to 100% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

(b) Provisions Applicable Prior to January 1, 2013. With respect to Matching Contributions for Lawrence or Brockton Operating Employees that were made prior to January 1, 2013, the following provisions applied:

1. Hired/Rehired On or After January 1, 2008. With respect to each Lawrence or Brockton Operating Participant who was an AB II Participant under the Bay State Union Plan (i.e., hired or rehired on or after January 1, 2008 but before January 1, 2013), the same Matching Contribution set forth under subsection II.04A(i)(a)2, above (applicable to AB II Benefit Participants) applied.

2. Hired/Rehired Before 2008. With respect to each Participant who was a FAP Participant under the Bay State Union Plan (i.e., hired or rehired prior to January 1, 2008), the Matching Contribution for each such Lawrence or Brockton Operating Employee shall be an amount equal to 50% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 5% of the total Compensation of such Participant.

(ii) Brockton C/T Employees.

(a) In General. Effective January 1, 2013, all Participants who are Brockton C/T Employees are considered AB II Participants under the Bay State Pension Plan. Further, effective June 1, 2013, any newly hired or rehired Brockton C/T Employees on or after such date are Next Gen Employees. Accordingly, Brockton C/T Employees are subject to subparagraphs 1 or 2 below, as applicable.

1. Next Gen Employees. Each Brockton C/T Employee who is hired or rehired on or after June 1, 2013 is considered a Next Gen Employee. In accordance with subsection F of Schedule I, each such Participant shall be entitled to a Matching Contribution equal to 50% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

2. Employees Considered AB II Participants. All Participants who are Brockton C/T Employees who are not Next Gen Employees as described above are considered AB II Participants under the Bay State Union Plan as of January 1, 2013. In accordance with the provisions of subsection A of Schedule I, the Matching Contribution for such Participants shall be an amount equal to 100% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

(b) Provisions Applicable Prior to January 1, 2013. With respect to Matching Contributions for Brockton C/T Employees that were made prior to January 1, 2013, the following provisions applied:

1. Hired/Rehired On or After January 1, 2008. With respect to each Brockton C/T Participant who was an AB II Participant under the Bay State Pension Plan (*i.e.*, hired or rehired on or after January 1, 2008), the same Matching Contribution set forth under subparagraph (ii)(a)2 above of this Section II.04A (applicable to AB II Benefit Participants) applied.

2. Hired/Rehired Before 2008. With respect to each Brockton C/T Participant who was a FAP Participant under the Bay State Pension Plan (*i.e.*, hired or rehired prior to January 1, 2008), the Matching Contribution was calculated in accordance with (a) or (b) below, as applicable.

   (a) For each Participant who was not eligible for post-retiree medical coverage (or who waived such post retiree medical coverage in accordance with procedures prescribed by the Plan Administrator) pursuant to the collective bargaining agreement in effect on October 1, 1995 for Brockton C/T Employees, and regardless of whether such Participant later became eligible for such coverage, the Matching Contribution shall be an amount equal to (a) 100% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 1% of the total

Compensation of such Participant, and (b) 50% of the Pre–tax Contribution and Roth Contribution made by each Participant on the next 5% of the total Compensation of such Participant. Accordingly, no Matching Contribution shall be made on such Participant's Pre–tax Contributions or Roth Contributions in excess of 6% of his Compensation.

(b) For any other Participant subject to this subsection (ii)(b)2 (*i.e.*, for Brockton C/T Employees hired or rehired prior to January 1, 2008 but previously eligible for (or not waiving) post-retiree medical benefits as described in subsection (a) above), the Matching Contribution shall be an amount equal to 50% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 5% of the total Compensation of such Participant.

(iii) Northampton Employees.

(a) In General. Participants who are Northampton Employees are considered either Next Gen Employees or FAP Participants under the Bay State Union Plan and are subject to subparagraphs 1 or 2 below, as applicable.

1. Next Gen Employees. Each Northampton Participant hired or rehired on or after January 1, 2011 is considered a Next Gen Employee. Accordingly, each such Participant shall be entitled to a Matching Contribution equal to 50% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

2. Northampton FAP Participants. All Participants who are Northampton Employees hired/rehired prior to January 1, 2011 (*i.e.*, not Next Gen Employees) are considered FAP Participants under the Bay State Union Plan. Each such Participant shall be entitled to a Matching Contribution equal to 50% of the Pre–tax Contribution and Roth Contribution made by or for each Participant, not to exceed 5% of the total Compensation of such Participant.

(iv) Springfield C/T Employees.

(a) In General. Effective January 1, 2013, Participants who are Springfield C/T Employees are considered either Next Gen Employees or AB II Participants under the Bay State Union Plan and are subject to subparagraphs 1 or 2 below, as applicable.

1. Next Gen Employees. Each Springfield C/T Participant hired or rehired on or after January 1, 2011 is considered a Next Gen Employee. Accordingly, each such Participant shall be entitled to a Matching Contribution equal to 50% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

2. Employees Considered AB II Participants. Effective January 1, 2013, all Participants who are Springfield C/T Employees hired/rehired prior to January 1, 2011 (i.e., not Next Gen Employees) are considered AB II Participants under the Bay State Union Plan. Accordingly, in accordance with the provisions of subsection A of Schedule I, each such Participant shall be entitled to a Matching Contribution equal to 100% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

(b) Provisions Applicable Prior to January 1, 2013. With respect to Matching Contributions for Springfield C/T Employees that were made prior to January 1, 2013, the following provisions applied:

1. Hired/Rehired in 2011 or Later. As stated above, each Participant who was a Springfield C/T Employee hired or rehired on or after January 1, 2011 was considered a Next Gen Employee and was subject to the same Matching Contribution set forth under subparagraph (iv)(a)(1) above of this Section II.04A.

2. Hired/Rehired Before 2011. With respect to each Springfield C/T Participant who was a FAP Participant under the Bay State Pension Plan (i.e., hired or rehired prior to January 1, 2011 and prior to the AB II conversion on January 1, 2013), the Matching Contribution shall be an amount equal to (a) 100% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 2.5% of the total Compensation of such Participant, and (b) 50% of the Pre-tax Contribution and Roth Contribution made by each Participant on the next 5% of the total Compensation of such Participant. Accordingly, no Matching Contribution shall be made on such Participant's Pre-tax Contributions or Roth Contributions in excess of 7.5% of his Compensation.

(v) Springfield Utility Employees.

(a) In General. Effective January 1, 2014, Participants who are Springfield Utility Employees are considered either Next Gen

Employees or AB II Participants under the Bay State Union Plan and are subject to subparagraphs 1 or 2 below, as applicable.

1. Next Gen Employees. Each Springfield Utility Participant hired or rehired on or after January 1, 2014 is considered a Next Gen Employee. Accordingly, each such Participant shall be entitled to a Matching Contribution equal to 50% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

2. Employees Considered AB II Participants. Effective January 1, 2014, all Participants who are Springfield Utility Employees hired/rehired prior to January 1, 2014 (*i.e.*, not Next Gen Employees) are considered AB II Participants under the Bay State Union Plan. Accordingly, in accordance with the provisions of subsection A of Schedule I, each such Participant shall be entitled to a Matching Contribution equal to 100% of the Pre–tax Contribution, Roth Contribution and After–tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

(b) Provisions Applicable Prior to January 1, 2014. With respect to Matching Contributions for Springfield Utility Employees that were made prior to January 1, 2014, the Matching Contribution shall be an amount equal to 50% of the Pre–tax Contribution and Roth Contribution made by or for each Participant, not to exceed 5% of the total Compensation of such Participant.

B. Matching Allocation. Notwithstanding the matching allocation provisions of Section 3.05, in accordance with the Plan enrollment provisions set forth in Section II.03 subsection B or C, as applicable, a Bay State Union Employee shall become eligible to receive Matching Contributions upon becoming a Participant in the Plan and making Pre–tax Contributions or Roth Contributions (*i.e.*, on the first day of the month following the completion of a 60–day Period of Service or upon Employment Commencement Date, as applicable).

C. Matching Contribution Investment. Notwithstanding the matching allocation provisions of Section 3.05 and Section 8.07, Matching Contributions contributed on behalf of Bay State Union Employees shall be invested in accordance with the investment allocation selected by each Bay State Union Employee, in accordance with Section 8.05 and 8.06, rather than invested automatically in the Company Stock Fund. Notwithstanding the foregoing, Matching Contributions contributed on behalf of Bay State Union Employees who are Next Gen Employees shall be automatically invested in the Company Stock Fund in accordance with Section 3.05 and Section 8.07.

Section II.05 PROFIT SHARING CONTRIBUTIONS AND NEXT GEN EMPLOYER CONTRIBUTIONS. As provided in Section 3.07A regarding eligibility for Profit Sharing Contributions, no Bay State collective bargaining agreement currently provides for a Profit Sharing Contribution to be allocated to any Bay State Union Employee.

Notwithstanding the foregoing, for any Bay State Union Employee who is a Next Gen Employee, the Employer shall contribute a Next Gen Employer Contribution each pay period to the Account of each such Participant in an amount equal to 3% of such Participant's total Compensation for that pay period (as applicable for Next Gen Employees) in accordance with the provisions set forth in Section 3.06C (applicable to Next Gen Employees). Also in accordance with Section 3.06C, the Next Gen Employer Contribution shall be payable regardless of whether Next Gen Employee Participants have elected to make any elective deferrals to the Plan and regardless of the Participant's status as of the end of the Plan Year. The Next Gen Employer Contribution shall be allocated to the Company Stock Fund and shall be 100% vested and nonforfeitable at all times.

Section II.06 DISTRIBUTIONS AND WITHDRAWALS. The provisions of Article IV (regarding payment of benefits) and Article V (regarding in–service withdrawals and loans) shall be applicable to the Account balance of any Bay State Union employee in the same manner as other Account balances.

SCHEDULE III

SPECIAL PROVISIONS FOR NIPSCO UNION EMPLOYEES

Section III.01 BACKGROUND AND APPLICABILITY. Effective December 31, 2008 (the "Merger Date"), the Northern Indiana Public Service Company Bargaining Unit Tax Deferred Savings Plan ("NIPSCO 401(k) Plan") merged into the Plan and the assets of the NIPSCO 401(k) Plan transferred to the Plan. After the Merger Date, NIPSCO Union Employees participate in and are subject to the terms of the Plan and this Schedule III.

Prior to the Merger Date, NIPSCO Union Employees participated in and were governed by the terms of the NIPSCO 401(k) Plan. While operated as a separate plan with a separate trust up until the Merger Date, the NIPSCO 401(k) Plan is amended and restated pursuant to the terms of this restated Plan document (including this Schedule III) as of the Effective Date shall be operated in accordance with the terms set forth in the Plan as modified by this Schedule III.

The NIPSCO 401(k) Plan has been operated in accordance with all applicable recent legislation, including without limitation, the Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA") (as such provisions were previously adopted and reflected in a restated plan document effective January 1, 2003); revisions required to comply with Internal Revenue Code Section 415; the Pension Protection Act of 2006 (PPA); and the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART"). Upon amendment of the Plan to comply with all recent legislation (whether by this restated Plan or subsequent amendment), such amendment shall also apply to the assets transferred from the NIPSCO 401(k) Plan, and such plan shall be deemed to have been amended effective as of the specified date(s) required by applicable legislation.

Section III.02 PLAN VS. SPECIAL PROVISIONS. Except as set forth in this Schedule III or as specifically otherwise provided elsewhere in the Plan, the provisions of the Plan shall apply to NIPSCO Union Employees. This Schedule III sets forth special provisions that shall apply solely to NIPSCO Union Employees.

Section III.03 ELIGIBILITY, PARTICIPATION AND ENROLLMENT. The provisions of Article II (regarding Plan eligibility and enrollment) shall apply to the Account balance of any NIPSCO Union Employee in the same manner as other Account balances as described therein. Accordingly, NIPSCO Union Employees are eligible to participate in the Plan on their Employment Commencement Date or Reemployment Commencement Date and shall be subject to the general enrollment provisions. However, the automatic enrollment provisions of Section 2.01B shall not apply to any NIPSCO Union Employee hired prior to June 1, 2009. The Automatic Percentage Amount for NIPSCO Union Employees hired on or after June 1, 2009 shall be 3% of Compensation. The Automatic Percentage Amount for any NIPSCO Union Employees hired on or after January 1, 2015 shall be 6% of Compensation.

Section III.04 MATCHING CONTRIBUTIONS. The Matching Contributions of NIPSCO Union Employees shall be determined in accordance with Section 3.04 and 3.05, and Schedule I.

Section III.05 PROFIT SHARING CONTRIBUTIONS. As provided in Section 3.07A regarding eligibility for Profit Sharing Contributions for Employees subject to collective bargaining agreements, no NIPSCO collective bargaining agreement currently provides for a Profit Sharing Contribution to be allocated to any NIPSCO Union Employee. For purposes of this Section III.05, former employees of NIFL and Kokomo who became employees of NIPSCO pursuant to the merger of those entities effective July 1, 2011 shall be considered NIPSCO Union Employees. The prior Kokomo or NIFL collective bargaining agreements did not provide for a Profit Sharing Contribution to be allocated to any such former employees of NIFL and Kokomo and, pursuant to the foregoing sentence, the current NIPSCO collective bargaining agreement to which such former NIFL and Kokomo employee became subject also does not provide for a Profit Sharing Contribution to Employees subject to the agreement.

COLUMBUS/1747809v 3

FIRST AMENDMENT
TO THE
NISOURCE INC. RETIREMENT SAVINGS PLAN

Background Information

A. NiSource Inc. ("NiSource") maintains the NiSource Inc. Retirement Savings Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee") has the power to amend and modify the Plan pursuant to Section 14.02 thereof.

C. On July 1, 2015 (the "Effective Date"), NiSource implemented the spin-off of its pipeline and transmission business, comprised of Columbia Pipeline Group, Inc. and its related entities, to become independent and non-related to NiSource (the "CPG Spin-Off").

D. The Committee desires to amend the introduction of the Plan, as of the Effective Date, to describe the CPG Spin-Off and address its impact on the Plan, and also to expand the ability to take in-kind withdrawals and distributions from the Plan to any stock funds held under the Plan.

Plan Amendment

1. The portion of the introduction of the Plan entitled Plan Background, regarding the history of the Plan, is amended by the addition of the following paragraph, included at the end of the last sentence of the Plan Background section:

> Effective as of the July 1, 2015, NiSource implemented the spin-off of its pipeline and transmission business, comprised of the Columbia Pipeline Group, Inc. ("CPG") and its related entities (collectively, the "CPG Entities"), to become independent and non-related to NiSource (the "CPG Spin-Off"). Prior to July 1, 2015, Employees of the CPG Entities participated in the Plan. Effective July 1, 2015, in connection with the CPG Spin-Off, the NiSource Benefits Committee, Plan Administrator and Named Fiduciary having amendment authority over the Plan, authorized the transfer of assets and liabilities of certain Participants and Former Participants in the Plan who are, or were prior to termination of employment, employees of the CPG Entities, to the Columbia Pipeline Group 401(k) Savings Plan, a new qualified defined contribution plan to be established by CPG. Pursuant to said transfer and the existing terms of the Plan, effective July 1, 2015, the Plan terms no longer apply to the above-mentioned Participants.

2. Section 5.01E of the Plan, regarding general rules applicable to withdrawals, is amended in its entirety to read as follows:

> Any withdrawals under this Article V may be made in cash or, with respect to the portion of a Participant's Account invested in the Company Stock Fund or any other stock fund maintained under the Plan, in kind at the Participant's election.

3. Section 4.04A and B of the Plan, regarding the form of benefit payment for distributions, are amended in their entirety to read as follows:

A. In a single lump sum payment in cash, or if elected by the Participant or Beneficiary, in shares of stock held in the Company Stock Fund or any other stock fund maintained under the Plan based on the number of whole shares allocated to the Company Stock Fund or other stock fund for the Participant; or

B. In a partial lump sum payment in cash or, if elected by the Participant or Beneficiary, in shares of Company Stock or any other stock fund maintained under the Plan, with the remainder of the Account paid later as elected by the Participant pursuant to this Section.

4. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this First Amendment to the NiSource Inc. Retirement Savings Plan to be executed on its behalf, by one of its members duly authorized, to be effective July 1, 2015, or such other date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Date: 6/22/15

SECOND AMENDMENT
TO THE
NISOURCE INC. RETIREMENT SAVINGS PLAN

Background Information

A. NiSource Inc. ("NiSource") maintains the NiSource Inc. Retirement Savings Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee") has the power to amend and modify the Plan pursuant to Section 14.02 thereof.

C. The Committee desires to amend the Plan, as of the dates set forth herein, to incorporate provisions relating to collectively bargained employees who are Plan participants, including matching contribution and automatic enrollment provisions applicable to specified groups of employees, and to otherwise clarify Plan terms.

Plan Amendment

1. Section II.03C of Schedule II to the Plan, regarding the eligibility, participation and enrollment provisions applicable to Bay State Union Employees is hereby amended in its entirety effective as of January 1, 2016 to read as follows:

C. Participation and Enrollment Modifications, and Application of Automatic Enrollment for Specified Employees. Notwithstanding the provisions of Section II.03B above, Bay State Union Employees shall both (i) become Participants upon their Employment Commencement Date (meaning that the 60-day Period of Service provision from Section II.03B above shall not apply) and (ii) be subject to the automatic enrollment provisions set forth in Section 2.01B of the Plan, as set forth below.

(i) Participation. Bay State Union Employees shall become Participants upon their Employment Commencement Date as provided in the following schedule:

- Lawrence Employees hired or rehired on or after January 1, 2008.
- Brockton Operating Employees hired or rehired on or after January 1, 2008.
- Brockton C/T Employees hired or rehired on or after January 1, 2008.
- Northampton Employees hired or rehired on or after January 1, 2011.

- Springfield C/T Employees hired or rehired on or after January 1, 2011.

- Springfield Utility Employees hired or rehired on or after January 1, 2014.

(ii) Automatic Enrollment. The Automatic Percentage Amount for each group of Bay State Union Employees shall be 3% of Compensation, except as provided in the schedule below:

- The Automatic Percentage Amount for Northampton Employees hired or rehired on or after January 1, 2016 shall be 6% of Compensation.

- The Automatic Percentage Amount for Springfield C/T Employees hired or rehired on or after January 1, 2016 shall be 6% of Compensation.

2. Section II.04A(iii) of Schedule II to the Plan, regarding the Matching Contributions applicable to Northampton Employees is hereby amended in its entirety effective as of April 1, 2015 to read as follows:

a. In General. Effective April 1, 2015, Participants who are Northampton Employees are considered either Next Gen Employees or AB II Participants under the Bay State Union Plan and are subject to subparagraphs 1 or 2 below, as applicable.

1. Next Gen Employees. Each Northampton Participant hired or rehired on or after January 1, 2011 is considered a Next Gen Employee. Accordingly, each such Participant shall be entitled to a Matching Contribution equal to 50% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

2. Employees Considered AB II Participants. Effective April 1, 2015, all Participants who are Northampton Employees hired/rehired prior to January 1, 2011 (i.e., not Next Gen Employees) are considered AB II Participants under the Bay State Union Plan. Accordingly, in accordance with the provisions of subsection A of Schedule I, each such Participant shall be entitled to a Matching Contribution equal to 100% of the Pre-tax Contribution, Roth Contribution and After-tax Contribution made by or for each Participant, not to exceed 6% of the total Compensation of such Participant.

b. Provisions Applicable Prior to April 1, 2015. With respect to Matching Contributions for Northampton Employees that were made prior to April 1, 2015, the following provisions applied:

1. Hired/Rehired in 2011 or Later. As stated above, each Participant who was a Northampton Employee hired or rehired on or after January 1, 2011 was

considered a Next Gen Employee and was subject to the same Matching Contribution set forth under subparagraph (iv)(a)(1) above of this Section II.04A.

2. Hired/Rehired Before 2011. With respect to each Northampton Participant who was a FAP Participant under the Bay State Pension Plan (i.e., hired or rehired prior to January 1, 2011 and prior to the AB II conversion on April 1, 2015), the Matching Contribution shall be an amount equal to 50% of the Pre-tax Contribution and Roth Contribution made by or for each Participant, not to exceed 5% of the total Compensation of such Participant.

3. The last two sentences of Section III.03 regarding eligibility, participation and enrollment of NIPSCO Union Employees is hereby amended to read as follows, for the purposes of clarifying application to employees hired or rehired on or after the noted dates, consistent with Section 2,01B(iii) of the Plan:

The Automatic Percentage Amount for NIPSCO Union Employees hired or rehired on or after June 1, 2009 shall be 3% of Compensation. The Automatic Percentage Amount for any NIPSCO Union Employees hired or rehired on or after January 1, 2015 shall be 6% of Compensation.

4. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this Second Amendment to the NiSource Inc. Retirement Savings Plan to be executed on its behalf, by one of its members duly authorized, to be effective as of such date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Richard L. Banks

Date: 12/23/15

COLUMBUS/1791693v.1

THIRD AMENDMENT
TO THE
NISOURCE INC. RETIREMENT SAVINGS PLAN

Background Information

A. NiSource Inc. ("NiSource") is the Plan Sponsor of the NiSource Inc. Retirement Savings Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee"), acting on behalf of NiSource as the Plan Sponsor, has the power to amend and modify the Plan pursuant to Article XIV thereof.

C. The Committee desires to amend the Plan, as of the date set forth herein, to incorporate provisions relating to the liquidation of the Columbia Pipeline Group stock fund (which is included in the Plan as a frozen investment option as a result of the July 1, 2015 corporate spin-off of by NiSource of its pipeline and transmission business, comprised of Columbia Pipeline Group, Inc. and its related entities, as an independent entity) as an investment option in the Plan.

Plan Amendment

1. The Company, as Plan Sponsor, hereby amends Section 8.04 of the Plan, regarding Investment Funds, effective as of February 24, 2016 by the addition of a new paragraph at the end of the Section to read as follows:

> Notwithstanding the foregoing, the Columbia Pipeline Group Stock Fund held in the Plan as a frozen investment option as a direct result of the corporate spin-off of Columbia Pipeline Group, Inc. to the shareholders of the Company (including shareholders within the Plan through the Company Stock Fund) on July 1, 2015 shall be removed as an investment option effective as of 4:00 p.m. Eastern time on June 30, 2016 and shall not thereafter be offered as an investment option under the Plan.

2. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this Third Amendment to the NiSource Inc. Retirement Savings Plan to be executed on its behalf, by one of its members duly authorized, to be effective as of such date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: Richard L. Bond

Date: 9/13/16

COLUMBUS/1803414v.2

FOURTH AMENDMENT
TO THE
NISOURCE INC. RETIREMENT SAVINGS PLAN

Background Information

A. NiSource, Inc. ("NiSource") is the Plan Sponsor of the NiSource Inc. Retirement Savings Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee"), acting on behalf of NiSource as the Plan Sponsor, has the power to amend and modify the Plan pursuant to Article XIV thereof.

C. The Committee desires to amend the Plan, effective as of June 21, 2016, to modify the provisions relating to investment options to be offered under the Plan.

Plan Amendment

1. Section 8.04 of the Plan, regarding Investment Funds, as previously amended, is further amended by revising the first paragraph thereof in its entirety to read as follows:

> The Committee and the Trustee shall establish certain investment funds (the "Investment Funds"), rules governing the administration of the Investment Funds, and procedures for directing the investment of Participant Accounts among the Investment Funds. Among these investment funds shall be the Company Stock Fund as defined in Article I and as further described in Section 8.08 of this Article, which remains at all times invested primarily in Company Stock. The Trustee shall invest and reinvest the principal and income of each Account in the Trust Fund as required by ERISA and as directed by Participants. The Committee reserves the right to change the investment options available under the Plan and the rules governing investment designations at any time and from time to time; provided, however, that the Committee shall at all times maintain the Company Stock Fund as an investment fund option.

2. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this Fourth Amendment to the NiSource Inc. Retirement Savings Plan to be executed on its behalf, by one of its members duly authorized, to be effective as of such date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Date: 9/13/16

COLUMBUS/1812416v.3

FIFTH AMENDMENT
TO THE
NISOURCE INC. RETIREMENT SAVINGS PLAN

Background Information

A. NiSource, Inc. ("NiSource") is the Plan Sponsor of the NiSource Inc. Retirement Savings Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee"), has the power to amend the Plan pursuant to Article XIV thereof.

C. The Committee desires to amend the Plan, effective as of June 1, 2016, unless otherwise stated below, to modify the provisions relating to employee and employer contribution determination under the Plan for specified participants in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459, as negotiated pursuant to the Memorandum of Understanding ("MOU"), generally effective June 1. 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC and the Company with respect to such position for the period specified in the MOU from June 1, 2016 (or as otherwise applicable) to April 30, 2019.

Plan Amendment

1. Effective as of September 1, 2016, Section 1.20A of the Plan, specifying "Considerations by Specific Group" under the definition of "Compensation," is hereby amended by adding a new subsection A(v) to such Section, to read as follows:

> For Participants who are employed in the position of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding resulting from collective bargaining with respect to such position between the United Steelworkers of America, Local 12775, AFL-CIO-CLC and the Company generally effective June 1, 2016 (hereinafter, "Damage Prevention Coordinator"), the definition of Compensation for purposes of determining Participant Contributions under Section 3.02 shall be determined under the provisions of subsection A(iii) above that is applicable for NIPSCO Union Employees who are AB I Participants.

2. Section 1.38 of the Plan, defining "Next Gen Employee," is hereby amended by the addition of a new subparagraph "G" to the end of such Section, to read as follows:

> G. any Employee employed in the position of Damage Prevention Coordinator who was a Next Gen Employee under the Plan

immediately prior to June 1, 2016, or, if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator. Effective as of May 1, 2019, Employees employed in the position of Damage Prevention Coordinator shall no longer be considered Next Gen Employees for Plan purposes, unless otherwise negotiated in an agreement between the bargaining unit and the Company.

3. Section 1.44 of the Plan, defining "NIPSCO Union Employee," is hereby amended by the addition of a new paragraph at the end of such Section, to read as follows:

In addition, solely for purposes of the Plan and employer contributions accruing hereunder, any Employee employed in the position of Damage Prevention Coordinator shall not be considered a NIPSCO Union Employee unless such Employee was considered a NIPSCO Union Employee immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator. Effective as of May 1, 2019, Employees employed in the position of Damage Prevention Coordinator shall be shall be considered NIPSCO Union Employees for Plan purposes, unless otherwise negotiated in an agreement between the bargaining unit and the Company.

4. Section 3.06C of the Plan, describing Next Gen Contributions, is hereby amended by the addition of a new paragraph at the end of such Section, to read as follows:

Any Employee employed in the position of Damage Prevention Coordinator who was a Next Gen Employee immediately prior to becoming employed in the position of Damage Prevention Coordinator shall remain a Next Gen Employee for purposes of Next Gen Contributions described in this subparagraph for the duration of his employment in such position during the period from June 1, 2016 to April 30, 2019. For any new hire during this period into the position of Damage Prevention Coordinator, Next Gen Contributions shall apply. Effective as of May 1, 2019, the date on which Employees employed in the position of Damage Prevention Coordinator shall become NIPSCO Union Employees for all Plan purposes, Plan provisions regarding Next Gen Contributions shall not apply to Employees in the position of Damage Prevention Coordinator, unless otherwise negotiated in an agreement between the bargaining unit and the Company.

5. Schedule I of the Plan, describing special provisions for Matching Contributions, is hereby amended by the addition of a new paragraph "G" to follow existing paragraph "F" to read as follows:

G. Special Provision for Damage Prevention Coordinators from June 1, 2016 to April 30, 2019. For any Employees employed in the position of Damage Prevention Coordinator during the period from

June 1, 2016 to April 30, 2019, Matching Contributions for such Employees shall be determined according to the Matching Contribution provision in effect for the Employee under subsection A, subsection B or subsection F above, as applicable, immediately prior to becoming employed in the position of Damage Prevention Coordinator. For any new hire during this period into the position of Damage Prevention Coordinator, Matching Contributions shall be determined under subsection F above. Effective as of May 1, 2019, Matching Contributions for Employees employed in the position of Damage Prevention Coordinator shall be determined according to subparagraph E above.

6. Section III.04 of Schedule III of the Plan, describing Matching Contribution provisions for NIPSCO Union Employees, is hereby amended by the addition of a new paragraph at the end of such Section, to read as follows:

Pursuant to Section 1.44 of the Plan, as amended, for any Employee employed in the position of Damage Prevention Coordinator, Matching Contributions shall be determined as provided in Schedule I, as amended during the period from June 1, 2016 to April 30, 2019.

7. Section III.05 of Schedule III of the Plan, describing Profit Sharing Contribution provisions for NIPSCO Union Employees, is hereby amended by the addition of a new paragraph at the end of such Section, to read as follows:

Notwithstanding the foregoing, and pursuant to Section 1.44 of the Plan, as amended, any Employee employed in the position of Damage Prevention Coordinator during the period from June 1, 2016 to April 30, 2019 and eligible for Profit Sharing Contributions immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in or transferring to the position of Damage Prevention Coordinator, shall be eligible for Profit Sharing Contributions under the Plan while employed in such position to the extent and on the same terms applicable to such Employees immediately prior to employment in the position of Damage Prevention Coordinator. In addition, any Employee who is a new hire during the period from June 1, 2016 to April 30, 2019 into the position of Damage Prevention Coordinator shall be eligible for Profit Sharing Contributions under the provisions set forth in Sections 3.06 and 3.07 of the Plan. In clarification of the foregoing, no Employee employed in the position of Damage Prevention Coordinator during the period from June 1, 2016 to April 30, 2019 shall be subject to the first paragraph above that provides no Profit Sharing Contributions for NIPSCO Union Employees.

8. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this Fifth Amendment to the NiSource Inc. Retirement Savings Plan to be executed on its behalf, by one of its members duly authorized, to be effective as of such date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: _____

Date: 12/21/16

COLUMBUS/1828035v.2

SIXTH AMENDMENT
TO THE
NISOURCE INC. RETIREMENT SAVINGS PLAN

Background Information

A. NiSource Inc. ("NiSource") is the Plan Sponsor of the NiSource Inc. Retirement Savings Plan, amended and restated effective as of January 1, 2014 (the "Plan").

B. The NiSource Benefits Committee (the "Committee"), has the power to amend the Plan pursuant to Article XIV thereof.

C. The Committee desires to amend the Plan, effective as of July 1, 2017, to remove the requirement that specified employer contributions be invested in the NiSource company stock fund investment option of the Plan (the "Company Stock Fund") at the time of contribution with respect to contributions to all non-union participants in the Plan, and thereby permit investment of such contribution for such participants in accordance with the participants' investment elections or, absent such elections, in the "qualified default investment alternative" ("QDIA") applicable to such participants under the Plan.

D. The Committee also desires to amend the Plan to clarify that Columbia Energy Group ("Columbia") is no longer a member of the NiSource Inc. controlled group of companies.

Plan Amendment

1. The section titled "Plan Background" in the Introduction of the Plan shall be amended by replacing the last sentence of the first paragraph with the following:

> Columbia, Bay State, Kokomo, NIFL became wholly-owned subsidiaries of NiSource Inc. effective as of the dates described in the Plan 2006 Restatement. Effective as of the CPG Spin-Off (defined herein), Columbia is no longer a recognized operating entity or member of the NiSource Inc. controlled group of companies and thus no longer a wholly-owned subsidiary of NiSource Inc.

2. Section 1.13 of the Plan ("Columbia") shall be amended in its entirety as follows:

> Columbia. Effective as of the CPG Spin-Off, a Columbia Gas company that is a Related Employer of NiSource Inc. participating in the Plan, or any successor(s). Prior to the CPG Spin-Off, Columbia Energy Group, or any successor(s).

3. Section 1.15 of the Plan ("Columbia Union Employee") shall be amended in its entirety as follows:

> Columbia Union Employee. Effective as of the CPG Spin-Off, an Eligible Employee of NiSource Inc. (or any Related Employer of NiSource Inc., such as a Columbia Gas company), whose compensation, conditions of employment or position are covered by a collective bargaining agreement to which a Columbia Gas company, or its successor within the NiSource Inc. controlled group, was previously a party and which agreement calls for the Employee's participation in the Plan.
>
> Prior to the CPG Spin-Off, a Columbia Union Employee was an Eligible Employee of Columbia, as previously defined (or any Related Employer of Columbia), whose compensation, conditions of employment or position are covered by a collective bargaining agreement to which Columbia is a party and which agreement calls for the Employee's participation in the Plan.

4. Section 3.05 of the Plan ("Matching Contribution Allocation and Accrual of Benefit") shall be amended by replacing the second paragraph in its entirety with the following:

> Effective for contributions made on or after July 1, 2017, all Matching contributions shall be invested in accordance with Section 8.07 of the Plan. For contributions made prior to July 1, 2017, all Matching Contributions were initially allocated to the Company Stock Fund, except as otherwise provided in Schedule II. All Matching Contributions shall be 100% vested and nonforfeitable at all times.

5. Subsection (C) of Section 3.06 of the Plan ("Next Gen Employer Contributions"), as previously amended, shall be further amended in its entirety as follows:

> Next Gen Employer Contributions. Notwithstanding the foregoing, effective as of January 1, 2010, the Employer shall contribute each pay period to the Account of each Participant who is both an Eligible Employee and a Next Gen Employee at such time an amount equal to 3% of such Participant's total Compensation for that pay period (as defined in Article I). Such contribution shall be a "Next Gen Employer Contribution." This amount shall be payable to applicable Participants regardless of whether such Participants have elected to make Pre-Tax Contributions, Roth Contributions or any other elective deferrals to the Plan and regardless of the Participants' status as of the end of the Plan Year. As provided in Section 3.07B, this Next Gen Employer Contribution shall be invested in accordance with Section 8.07 of the Plan and shall be 100% vested and nonforfeitable at all times. Eligibility for a Next Gen Employer Contribution under this subparagraph C shall not preclude eligibility for any other Profit Sharing Contribution under the terms contained herein.

Any Employee employed in the position of Damage Prevention Coordinator who was a Next Gen Employee immediately prior to becoming employed in the position of Damage Prevention Coordinator shall remain a Next Gen Employee for purposes of Next Gen Contributions described in this subparagraph for the duration of his employment in such position during the period from June 1, 2016 to April 30, 2019. For any new hire during this period into the position of Damage Prevention Coordinator, Next Gen Contributions shall apply. Any Next Gen Employer Contributions made to such Damage Prevention Coordinators during this period shall be invested as contributions for union Participants are invested in accordance with Section 8.07 of the Plan, as amended. Effective as of May 1, 2019, the date on which Employees employed in the position of Damage Prevention Coordinator shall become NIPSCO Union Employees for all Plan purposes, Plan provisions regarding Next Gen Contributions shall not apply to Employees in the position of Damage Prevention Coordinator, unless otherwise negotiated in an agreement between the bargaining unit and the Company.

6. Subsection (B) of Section 3.07 of the Plan ("Allocation, Investment and Vesting") shall be amended in its entirety as follows:

Allocation, Investment and Vesting. Subject to Article XI and except as provided for contributions described under section 3.06C, the Plan Administrator shall allocate and credit to the Account of each Participant who satisfies the conditions of Section 3.07A a percentage of the annual Profit Sharing Contribution in the ratio that the sum of the Participant's total Compensation for the Plan Year bears to the sum of all such Participants' total Compensation for the Plan Year. Effective for contributions made on or after July 1, 2017, all Profit Sharing Contributions, including Next Gen Employer Contributions under Section 3.06C, shall be invested in accordance with Section 8.07 of the Plan. For contributions made prior to July 1, 2017, all Profit Sharing Contributions, including Next Gen Employer Contributions were initially allocated to the Company Stock Fund. All Profit Sharing Contributions, including Next Gen Employer Contributions under Section 3.06C, shall be 100% vested and nonforfeitable at all times.

7. Section 8.07 of the Plan ("Special Rules Pertaining to Investment of Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions") shall be amended in its entirety as follows:

Special Rules Pertaining to Investment of Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions. Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions (whether each is made in the form of cash or Company Stock, pursuant to Section 3.08) shall be allocated as follows:

A. Non-Union Employees. Effective for contributions made prior to July 1, 2017, all Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions made to the Accounts of non-union Participants were initially invested in the Company Stock Fund. Following such initial investment, in accordance with the provisions of Section 8.05 and 8.06, a Participant may elect to change such investment designation to a different Investment Fund.

Effective for contributions made on or after July 1, 2017, all Matching Contributions, Profit Sharing Contributions and Next Gen Employer Contributions made to the Accounts of non-union Participants shall be invested in accordance with the Participant's direction (or in the absence of Participant direction, according the applicable default) under the provisions of Sections 8.05 and 8.06.

B. Union Employees. Except as provided in the first sentence of Section II.04C of Schedule II with respect to Matching Contributions for Bay State Union Employees who are not Next Gen Employees, all Matching Contributions, Profit Sharing Contributions (if applicable) and Next Gen Employer Contributions (if applicable) made to the Accounts of union Participants on and after July 1, 2017 shall continue to be initially invested in the Company Stock Fund. In accordance with the provisions of Sections 8.05 and 8.06, a Participant may elect to change such investment designation to a different Investment Fund at any time after such initial contribution.

Effective January 1, 2007, with respect to the Participant's ability change such investment designation, the following provisions shall apply: (1) the Plan shall offer not less than three different Investment Funds, other than the Company Stock Fund, to which the Participant may direct the investment of his Account, each of which options is diversified and has materially different risk and return characteristics; (2) the Plan shall provide reasonable divestment and reinvestment opportunities no less than quarterly; and (3) except as provided in regulations, the Plan shall not impose restrictions or conditions on the investment of Company Stock which the Plan does not impose on the investment of other Plan assets, other than restrictions or conditions imposed by reason of the application of securities laws or a condition permitted under IRS Notice 2006-107 or other applicable guidance or any Company policy restricting Participant divestiture rights during specified periods.

8. Section III.04 of Schedule III of the Plan ("Matching Contributions" for NIPSCO Union Employees), as previously amended, shall be further amended by the addition of the following sentence to the end thereof:

> Any Matching Contributions made to such Damage Prevention Coordinators during this period shall be invested as contributions for union Participants are invested in accordance with Section 8.07 of the Plan, as amended.

9. Section III.05 of Schedule III of the Plan ("Profit Sharing Contributions" for NIPSCO Union Employees), as previously amended, shall be further amended by the addition of the following sentence at the end of the final paragraph thereof:

> Any such Profit Sharing Contributions that may be made to Damage Prevention Coordinators during this period shall be invested as contributions for union Participants are invested in accordance with Section 8.07 of the Plan, as amended.

10. All other provisions of the Plan shall remain unchanged.

[SIGNATURE BLOCK FOLLOWS ON NEXT PAGE]

The Committee has caused this Sixth Amendment to the NiSource Inc. Retirement Savings Plan to be executed on its behalf, by one of its members duly authorized, to be effective as of such date as set forth in this amendment.

NISOURCE BENEFITS COMMITTEE

By: Richard L. Bond

Date: 6/29/17

COLUMBUS/1847916v.4

NiSource

POLICY SUBJECT: **Holidays**

EFFECTIVE DATE: **January 1, 2015**

This policy sets forth the holiday schedule for regular full time and part time employees of NiSource companies whose terms and conditions of employment are not covered by a collective bargaining agreement.

Fixed Holidays

The following seven fixed holidays will be observed:

New Year's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Day

Fixed holidays falling on Saturday will be observed on the preceding Friday. Fixed holidays falling on Sunday will be observed on the following Monday. Each NiSource subsidiary can make alternate arrangements for days where business conditions require employees to be at work.

Employees working a non-traditional work week will have their holiday observed according to applicable work location schedule.

Floating Holidays

Five floating holidays will be granted. Each NiSource subsidiary can assign one or more of the floating holidays to specific days.

Any union to non-union transferee will be granted all 5 floating holidays regardless of transfer date, minus any Floating Holidays they may have already taken in calendar year.

Floating holidays cannot be carried over from year to year. Qualified employees may bank unused floating holidays within the limits of the vacation banking policy. Unused/unbanked floating holidays will not be paid at separation.

Floating Holiday Granting Process

Active employees will be granted five floating holidays on January 1 of each year. New hires will be granted floating holidays as follows:

If hired between January 1 and March 31, granted 4 floating holidays
If hired between April 1 and June 30, granted 3 floating holidays
If hired between July 1 and September 30, granted 2 floating holidays
If hired between October 1 and November 30, granted 1 floating holiday

Part-Time and Phased Retirement Employee Fixed Holidays and Floating Holidays

Part time employees will be paid their normal scheduled working hours for any fixed holiday that falls on their regularly scheduled workday.

Part time employees, regardless of work schedule, are eligible to receive two floating holidays (16 hours).

Part-Time Floating Holiday Granting Process

Active employees will be granted two floating holidays on January 1 of each year. New hires will be granted floating holidays as follows:

If hired between January 1 and June 30, granted 2 floating holidays
If hired between July 1 and November 30, granted 1 floating holiday

Mid-Year Full-Time to Part-Time Employee Change
Employee entitled to remaining full time floating holiday balance in year of change. Beginning January 1 of the year following the change, employee will be granting part time grant of 16 hours.

Mid-Year Part-Time to Full-Time Employee Change
Employee will be granted full time floating holiday balance minus any time taken as a part time employee during that year. Beginning January 1 of the year following the change, employee will follow full time floating holiday policy.

Temporary Employees

Temporary employees or interns are not eligible to receive holidays or floating holidays.

NiSource

POLICY SUBJECT: **Vacation**

EFFECTIVE DATE: **January 1, 2004**

REVISED: **September 23, 2015**

This policy covers regular full time and part time employees of NiSource companies whose terms and conditions of employment are not covered by a collective bargaining agreement. Note that an employee's individual vacation hours cannot be donated to another employee.

Vacation Year

The vacation year runs from January 1 through December 31 of each year.

Vacation Calculation

Vacation is granted on January 1 and is calculated based upon full years of service on the preceding December 31 (note the exception under New Hire and Rehired Employees). If service has been broken, the service date established upon return to employment will be used to calculate the vacation grant utilizing the vacation schedule in effect at time of rehire. Prior service as an intern, summer, or temporary employee will not count towards vacation eligibility.

In order to receive the annual grant, employees on short term or long term disability or any other type of leave of absence or non-work status must return to work at least one day in a new year.

New Hire and Rehired Employees

A new or rehired employee in the initial year of employment is granted vacation based on a proration of 3 weeks (120 hours) of vacation unless a rehired employee's eligible previous service makes the granted vacation 4 weeks (160 hours).

The proration is calculated based on the remaining full months in a calendar year beginning with the month after hire date month. For example:

> -Employee hired April 1, 2014; first year 2014 vacation entitlement would be 8/12 (May-Dec) x 120 hours = 80 hours taken with supervisor approval or remaining can be carried over subject to carryover limits. Beginning January 1, 2015, employee would be entitled to 3 weeks (120 hours) vacation (if applicable could be 160 hours for rehired employees depending on previous service and break-in-service).

NOTE: Any exceptions to these new hire and rehire provisions must be approved by the Sr. VP Human Resources.

2013 New or Rehired Employees

If an employee was hired or rehired in 2013, they will be granted on 1/1/14 either 3 weeks (120 hours) or 4 weeks (160 hours) depending on eligibility minus any borrowed hours used in 2013.

General Provisions

1. Vacation will be scheduled according to requirements established at the Company or Department level.
2. Vacation will be paid at the employee's regular base rate of pay, exclusive of any premium or temporary upgraded rate at the time the vacation is taken.
3. Employees are required to use 80 hours of their vacation grant per year or forfeit the difference between the number of hours used and 80 hours (exception would be in the first year of hire or rehire if vacation grant is less than 80 hours). However, if extenuating circumstances exist that are beyond the employee's control, an employee, with approvals from the employee's supervisor and the next level of management, may elect to carry over or to bank such unused vacation hours that would otherwise be subject to forfeiture.
4. After using 80 hours of their vacation grant, employees may elect to carry over up to 80 hours of unused vacation into the following year without supervisor approval. If extenuating circumstances exist that are beyond the employee's control, an employee, with approvals from the employee's supervisor and the next level of management, may elect to carry over more than 80 hours of unused vacation into the following year.
5. If no timely election has been made to carry over or to bank unused vacation hours, an employee will be deemed to have elected to carry over up to 80 unused vacation hours (assuming the employee has first used 80 hours of vacation) to the following year.
6. Any employee election referred to in this policy (other than the deemed election described immediately above) must be made in writing or electronically within the timeframes and in the manner prescribed by NiSource.

Vacation Banking

Employees age 45 and older ("qualified employees") are qualified to participate in the vacation banking program. After using 80 hours of their vacation grant, such employees may elect to bank up to 160 hours of unused vacation per year, up to a lifetime banking limit of 640 hours, during the annual vacation banking event.

If a qualified employee has not made an election to bank unused vacation hours or to carry over all such hours to the following year, such employee will be deemed to have elected first to carry over up to 80 unused vacation hours to the following year (assuming the employee has first used 80 hours of vacation), and then to have elected to bank up to 160 of any remaining unused vacation hours, subject to the lifetime banking limit.

At retirement or separation, qualified employees can bank unused vacation and floating holidays, subject to the annual limit of 160 hours and lifetime banking limit of 640 hours. Accrued vacation is not eligible for banking.

At retirement or separation, qualified employees will receive a lump-sum cash payment for their banked hours, calculated at their pay rate at the time they leave. They will have the option to defer part of the payment into their 401(k) plan based on their current deferral election on file with the 401K administrator, within IRS limits, and receive the eligible company match. In addition, the payment will count as additional eligible earnings toward retirees' final average pay or account balance pension calculations, if applicable.

Under the provisions of the federal Family and Medical Leave Act, qualified employees can "un-bank" and use banked vacation hours after they have depleted their available unused vacation and floating holiday hours for the year.

Vacation and Other Types of Leave

1. An employee will not be permitted to take vacation while receiving Worker's Compensation payments.
2. Vacation taken as a result of one of the conditions covered under the Family and Medical Leave Act (FMLA) will count toward the twelve-week FMLA maximum leave allowance.
3. Employees on reduced-pay or no-pay sick leave/short-term disability may request vacation paid in lieu to supplement sick pay.
4. Employees will not receive credit for vacation accrued while on long-term disability, workers compensation or a Leave of Absence unless they return to work full time within one year.
5. Vacation for employees entering Military Service is covered in the Military Leave of Absence Policy.

Vacation Paid at Long Term Disability
Accrued, Unused and Banked vacation will be paid to employees at the beginning of long-term disability or at the end of the year in which the employee began long-term disability. Payment will be calculated on the basis of 1/12 of the vacation eligibility for each completed month of service. The accrual rate will be based on full years of service at the time of Long Term Disability.

Vacation Paid at Separation
Unused and banked vacation will be paid to employees at separation.

Accrued vacation will be paid to employees at separation due to involuntary severance, retirement, or death. Payment will be calculated on the basis of 1/12 of the vacation eligibility for each completed month of service in the final year of employment. The accrual rate will be based on full years of service at the end of the year of separation.

An employee will be disqualified from the right to receive unused and banked vacation pay under the Policy for the following reasons:

- An employee does not return all company property.
- An employee owes an outstanding debt to the Company at time of separation.

Vacation Schedules – Exempt and Non Exempt employees prior to January 1, 2004
Existing employees on December 31, 2003 will be grandfathered to the vacation schedule in which they were enrolled on that date. Vacation schedules can be obtained from their Human Resource Consultant or the Human Resource Delivery Team.

Vacation Schedule – Exempt and Non-Exempt employees hired or rehired on or after January 1, 2004*

All Exempt employees hired or rehire between 01/01/04 and 12/31/09 and all Non Exempt employees hired between 1/1/04 and 12/31/12 will be covered by the following vacation schedule:

Full Years of Service at 12/31/XX	Vacation Hours Granted the Following Vacation Year
1	80
3	120
10	160

*This schedule also applies for nonexempt employees in CEG benefit plans who were hired or rehired between January 1, 2000 and December 31, 2012. Also, this schedule also applies to Exempt employees in CEG benefit plans who were hired or rehired between January 1, 2000 and December 31, 2009.

Vacation Schedule – Exempt Employees hired or rehired on or after January 1, 2010 and Non Exempt hired on or rehired after January 1, 2013

All Exempt employees hired or rehired on or after 01/01/10 and Non Exempt employees hired or rehired on or after January 1, 2013 will be covered by the following vacation schedule:

Full Years of Service at 12/31/XX	Vacation Hours Granted the Following Vacation Year
January 1 after initial year of hire*	120
4	160

*If applicable could be 160 hours for rehired employees depending on previous service and break-in-service.

Exempt employees hired or rehired on or after January 1, 2010 and Non Exempt employees hired or rehired on or after January 1, 2013 will receive an additional five "bonus" days of vacation only during the succeeding year after every five-year service anniversary.

For example, after completing five full years of service, an employee will receive five extra vacation days during the following calendar year (which means a total of 25 vacation days).

The following year, the employee's vacation level reverts back to the normal 20 days.

Non Exempt to Exempt Transfers

Non Exempt employees hired or rehired on or after January 1, 2010 and before January 1, 2013 who transfer to an Exempt position will be granted additional vacation hours (if applicable) January 1 of the following year.

Exempt or Nonexempt to Union Transfers

These transferred employees will be under the applicable union vacation schedule upon the date of transfer.

Union to Exempt or Non Exempt Transfers

These transferred employees will maintain applicable union vacation grant for the remainder of the year of transfer and then effective January 1 of the following year they will be under this nonunion vacation policy.

Vacation Schedule – Part-Time and Phased Retirement Employees
Part-time employees will be covered by one of the above schedules based on employment status and vacation plan participation as of hire date. Their annual vacation grant will be pro-rated based on the number of normal hours worked in a week.

Hours granted based on weekly schedule of normal hours worked:

30 - 39 hours per week-	85% of annual grant
20 - 29 hours per week-	65% of annual grant
15 - 19 hours per week-	45% of annual grant
14 or less hours per week-	25% of annual grant

New Hire and Rehired Part-Time Employees
A new or rehired part-time employee in the initial year of employment is granted vacation based on a proration of 3 weeks (120 hours) of vacation unless a rehired employee's eligible previous service makes the granted vacation 4 weeks (160 hours).

The proration is calculated based on the remaining full months in a calendar year beginning with the month after hire date month and the percent of annual grant above. For example:

> -Part-time employee hired April 1, 2014; first year vacation entitlement would be 8/12 (May-Dec) x 120 hours x 65% = 52 hours taken with supervisor approval or remaining can be carried over subject to carryover limits. Beginning January 1, 2015, employee would be entitled to 3 weeks (120 hours) pro-rated vacation based on their weekly schedule above.

NOTE: Any exceptions to these new hire and rehire provisions must be approved by the Sr. VP Human Resources.

Mid-Year Full-Time to Part-Time Employee Change
Employees entitled to remaining full time grant in year of change. Beginning January 1 of the year following the change part-time vacation determined by annual grant percentage above.

Mid-Year Part-Time to Full-Time Employee Change
Part-time and Full time months prorated based on month of change. Examples:

-Change effective March 1 and no vacation taken for that year as of change date.

9/12 (Apr-Dec) x 120 hours = 90 hours plus part-time annual grant 102 hours (85% of 120 hours) x 3/12 (Jan-Mar) = 26 hours so employee entitled to 116 hours (90 + 26) after change for that calendar year.

-Change effective March 1 and vacation used for that year as of change date.

9/12 (Apr-Dec) x 120 hours = 90 hours plus part-time annual grant 102 hours (85% of 120 hours) x 3/12 (Jan-Mar) = 20 hours minus 15 hours taken as of change date so employee entitled to 95 hours (90 + 20 -15) after change for that calendar year.

NISOURCE
TRAVEL ACCIDENT PLAN

As Amended and Restated Effective January 1, 2015

TABLE OF CONTENTS

Page

ARTICLE I INTRODUCTION 1

ARTICLE II DEFINITIONS 1
2.01 Beneficiary 1
2.02 Claims Administrator 1
2.03 Code 1
2.04 Company 1
2.05 Covered Person 1
2.06 Employee 1
2.07 Committee 1
2.08 Employer 1
2.09 ERISA 2
2.10 Full-Time Employee 2
2.11 Non-Represented 2
2.12 Plan 2
2.13 Plan Administrator 2
2.14 Related Employer 2
2.15 Construction 2

ARTICLE III ELIGIBILITY AND PARTICIPATION 2

ARTICLE IV BENEFITS 2
4.01 Death Benefit 2
4.02 Exclusions 3
4.03 Amount of Benefit 3
4.04 Payment of Benefits 3
4.05 Facility of Payment 3

ARTICLE V BENEFICIARY 3

ARTICLE VI ADMINISTRATION OF PLAN 3
6.01 Committee to Administer the Plan 3
6.02 The Committee 4
6.03 Powers of the Plan Administrator 4
6.04 Interpretative Authority 4
6.05 Appointment of the Claims Administrator 5

ARTICLE VII CLAIMS FOR BENEFITS 5
7.01 Consideration of Initial Claim 5
7.02 Claim Denial 5
7.03 Appeal Procedure for Denied Claims 5
7.04 If the Claims Administrator Denies a Claim on Appeal 6
7.05 Appeals to the Plan Administrator 6
7.06 Legal Actions 7
7.07 Autopsy 7

ARTICLE VIII TERMINATION OF PARTICIPATION 7

ARTICLE IX MISCELLANEOUS PROVISIONS 7
9.01 Information to Be Furnished 7
9.02 Limitation of Rights 7
9.03 Plan Not Contract 7
9.04 Fiduciary Operation 7
9.05 No Guaranty 8
9.06 No Limitation of Management Rights 8
9.07 Employees' Responsibilities 8
9.08 Right of Recovery 8
9.09 Governing Law and Venue 8
9.10 Severability 8
9.11 Participant Litigation 8
9.12 Counterparts 9
9.13 Notice 9
9.14 Extension of Plan to Related Employers 9

ARTICLE X FUNDING, AMENDMENT AND TERMINATION OF THE PLAN 9
10.01 Plan Self Insured 9
10.02 Rights Unsecured 9
10.03 Amendment 10
10.04 Termination 10
10.05 Collective Bargaining Agreement 10

ARTICLE I
INTRODUCTION

NiSource Inc. (the "Company") maintains the NiSource Travel Accident Plan (the "Plan") to provide life insurance protection for employees against the hazards of business travel. The Plan was amended and restated effective January 1, 2004, and was amended from time to time thereafter. Effective January 1, 2008, the Plan became a component welfare plan of the NiSource Welfare Benefits Program. The Plan was amended and restated effective January 1, 2013 and January 1, 2014. This is an amended and restated version of the Plan, effective January 1, 2015.

ARTICLE II
DEFINITIONS

2.01 **Beneficiary**. "Beneficiary" means the person, persons or entity designated under Article V to receive any Plan benefits payable after an Employee's death.

2.02 **Claims Administrator**. "Claims Administrator" means the NiSource Benefits Administration Department or such other person, persons or entity appointed by the Plan Administrator pursuant to Section 6.05.

2.03 **Code**. "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.04 **Company**. "Company" means NiSource Inc., a Delaware corporation.

2.05 **Covered Person** "Covered Person" means an Employee covered under the Plan.

2.06 **Employee** "Employee" means a regular employee of an Employer. No independent contractor shall be treated by the Plan Administrator as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Plan Administrator.

2.07 **Committee** "Committee" means the NiSource Benefits Committee or its predecessor, the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee.

2.08 **Employer**. "Employer" means the Company, any Related Employer, and any successor that shall maintain the Plan, but does not include (i) any Related Employer to the extent that a welfare benefit plan providing travel accident benefits is provided to the employees of such Related Employer (whether by the Related Employer or another entity) and such plan is not included as part of the Plan for purposes of reporting on Form 5500 filed with the Federal government, (ii) any Related Employer to the extent that an agreement related to the acquisition, sale or other disposition of the Related Employer provides that its employees shall not have coverage under the Plan, or (iii) any Related Employer that the Plan Administrator has determined in its discretion is not an "Employer" for purposes of the Plan. Any Related Employer that satisfies the conditions of the immediately preceding sentence for being an "Employer" shall be deemed to have adopted the Plan. Unless otherwise provided by the Plan Administrator, an Employer participating in the Plan shall automatically cease to participate in the Plan, without further action or notice by the Plan Administrator and without need for amendment or modification of the Plan, on the date that such entity is no longer considered a Related Employer of the Company. The Company and any applicable Related Employer may limit or extend the adoption of the Plan to one or more groups

of Employees and/or divisions, locations or operations. Without limiting the generality of the foregoing, prior to May 1, 2014, Lake Erie Land Company shall not be an Employer under the Plan; however, subject to the other provisions of this Section 2.08, Lake Erie Land Company shall be an Employer under the Plan on and after May 1, 2014.

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

2.10 **Full-Time Employee** "Full-Time Employee" means an Employee characterized by an Employer as a full-time employee who regularly works 40 or more hours per week.

2.11 **Non-Represented** "Non-Represented" means a Full-Time Employee who is not covered by a collective bargaining agreement between an Employer and a union.

2.12 **Plan**. "Plan" means the NiSource Travel Accident Plan set forth herein, together with any and all amendments and supplements thereto.

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

2.14 **Related Employer**. "Related Employer" means (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2.15 **Construction**. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

Each regular Non-Represented Full-Time Employee shall automatically be covered under the Plan on the first day of his or her active employment with an Employer.

ARTICLE IV
BENEFITS

4.01 **Death Benefit**.

(a) All eligible Non-Represented Full-Time Employees are covered anywhere in the world for Accidental Death sustained during the course of any trip made on behalf of an Employer. For purposes of the Plan, "Accidental Death" means a death which takes place without foresight or expectation that is not attributable to mistake, neglect or misconduct on the part of the Employee.

(b) For purposes of the Plan, the trip will be considered as commencing when the Employee leaves his or her residence or place of regular employment, whichever he or she leaves last, for the purpose of going on such trip, and the trip shall continue until the Employee returns to his or her residence or place of regular employment, whichever he or she returns to first.

(c) A business trip "made on behalf of an Employer" means travel and sojourn authorized by or at the direction of an Employer for the purposes of furthering the business of an Employer.

4.02 Exclusions. The Plan does not cover any Accidental Death incurred due to:

(a) commuting to and from work, and any travel during lunches, breaks and vacations;

(b) suicide or any attempt thereat while sane or self-destruction or an attempt thereat while insane;

(c) declared or undeclared war or any act of either within the United States, the District of Columbia or Canada;

(d) service in the armed forces of any country; provided, however, orders to active military service for two months or less shall not constitute service in the armed forces; or

(e) sickness or disease, except infections that occur through an accidental cut or wound.

4.03 Amount of Benefit. All eligible Non-Represented Full-Time Employees are covered for $50,000 in death benefits.

4.04 Payment of Benefits. The benefit under the Plan shall be paid directly to the Beneficiary as soon as practicable following the Employee's death. Benefits may be paid directly from the general assets of the Company or from any other lawful funding vehicle as may be established by the Company.

4.05 Facility of Payment. When a person entitled to benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the Plan.

ARTICLE V
BENEFICIARY

An Employee's Beneficiary shall be the beneficiary or beneficiaries designated under the NiSource Life Insurance Plan. If an Employee fails to designate a Beneficiary before his or her death, as provided above, or if the designated Beneficiary dies before the date of the Employee's death, the Plan Administrator shall pay such benefits according to the rules set forth in the NiSource Life Insurance Plan for payment of death benefits in the event no beneficiary is designated or there is no eligible beneficiary.

ARTICLE VI
ADMINISTRATION OF PLAN

6.01 Committee to Administer the Plan. The Plan shall be administered by the Committee. The Committee shall be the "Named Fiduciary" and the "Plan Administrator" within the meaning of

ERISA. The Committee may delegate its fiduciary responsibilities under the Plan to the extent permitted by ERISA.

6.02 **The Committee**. The powers of the Committee are set forth below and in the charter of the Committee, as such charter may be modified from time to time.

6.03 **Powers of the Plan Administrator**. The Plan Administrator shall have the duties and powers necessary to administer the Plan properly, including, but not limited to, the following:

(a) To maintain all Plan records;

(b) To file all required government reports and other documents;

(c) To provide required disclosures to Employees;

(d) To direct the Claims Administrator to process claims;

(e) To interpret the Plan, construe Plan terms and decide questions and disputes, which interpretations, constructions and decisions shall be conclusive for all purposes of the Plan;

(f) To make factual determinations;

(g) To determine eligibility for and the amount of benefits payable under the Plan;

(h) To determine the status and rights of all Employees;

(i) To make regulations and prescribe procedures;

(j) To authorize the Claims Administrator to make benefit payments to any person entitled to benefits under the Plan;

(k) To obtain from the Company, Covered Persons and others, such information as is necessary for the proper administration of the Plan;

(l) To determine and establish the level of cash reserves, if any, as may be necessary, appropriate or desirable to administer the Plan properly and accomplish its objectives;

(m) To retain and pay the reasonable expenses of such legal, consulting, medical, accounting, clerical and other assistance as it deems necessary or desirable to assist it in the administration of the Plan. The Plan Administrator shall be entitled to rely upon any information from any source assumed in good faith to be correct; and

(n) To exercise any other authority necessary, appropriate or helpful to manage and administer the Plan.

6.04 **Interpretative Authority**. The Plan Administrator has the full and final discretionary authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including, without limitation, the construction of the language of the Plan and the Summary Plan Description thereunder. Any writing, decision, determination of benefit eligibility or any other determination or instrument created by the Plan Administrator in connection with the operation of the Plan shall be binding upon all persons dealing with the Plan or claiming any benefits thereunder, except to

the extent that the Plan Administrator may subsequently determine, in its sole discretion, that its original decision was in error, or to the extent such decision may be determined to be arbitrary or capricious by a court or other entity having jurisdiction over such matters. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

6.05 **Appointment of the Claims Administrator.** The Plan Administrator may appoint a Claims Administrator to provide administrative services to the Plan Administrator in connection with the operation of the Plan and to perform such other functions, including processing and payment of claims, as may be delegated to it. The person, persons or entity serving as Claims Administrator shall serve at the pleasure of the Plan Administrator. In the absence of any appointment, the Benefits Administration Department shall serve as Claims Administrator.

ARTICLE VII
CLAIMS FOR BENEFITS

7.01 **Consideration of Initial Claim.** The Claims Administrator and the Plan Administrator shall process benefit claims pursuant to the procedures set forth below. Any claim for benefits shall be submitted in writing to the Claims Administrator. Any claim for benefits submitted after eighteen months from the date of a Covered Person's death may not be considered for payment.

7.02 **Claim Denial.** If a claim for benefits under the Plan is denied in whole or in part, the claimant shall receive a written explanation containing the following information: the specific reason or reasons for the denial; specific reference to the pertinent Plan provisions upon which the denial is based; a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and an explanation of the Plan's review procedures (as set forth below) and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse determination on all appeals.

7.03 **Appeal Procedure for Denied Claims.** If a claimant has a claim denied in full or in part, he or she has the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial.

A claimant may submit written comments, documents, records, and other information relating to his or her claim for benefits. Upon request, a claimant shall receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim.

A claimant's written request should state why he or she thinks the claim should not have been denied. The claimant's request shall include any denial letter he or she received and any additional documents, information or comments he or she thinks may have a bearing on the claim.

Upon receipt of a request for review, the Claims Administrator shall conduct a review that takes into account all comments, documents, records, and other information submitted by a claimant or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Any request for review made to the Claims Administrator shall be processed within 60 days of its receipt by the Claims Administrator unless the Claims Administrator determines that special

circumstances require an extension of time to process the appeal, in which event the claimant will be notified prior to the expiration of the initial 60-day period that an additional period of 60 days is required to process the appeal. The notice will include the special circumstances requiring the extension and the date by which the Claims Administrator expects to render its decision.

7.04 **If the Claims Administrator Denies a Claim on Appeal**. If the Claims Administrator denies all or any portion of a claim on appeal, it shall notify the claimant of the following, in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the denial is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; (4) a statement describing any voluntary appeal procedures offered by the Plan and a claimant's right to obtain information about such procedures; and (5) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims procedure process.

7.05 **Appeals to the Plan Administrator**. If the Claims Administrator denies all or any portion of the claim on appeal, the claimant may follow the appeal process established by the Plan Administrator. To start this process, the claimant must file an appeal with:

NiSource Inc.
801 E. 86th Avenue
Merrillville, Indiana 46410
Attn: NiSource Benefits Committee

within 60 days after an appeal has been denied in whole or in part by the Claim Administrator.

Any appeal to the Plan Administrator shall be processed within 60 days of its receipt by the Plan Administrator unless the Plan Administrator determines that special circumstances require an extension of time to process the appeal, in which event the claimant will be notified prior to the expiration of the initial 60-day period that an additional period of 60 days is required to process the appeal. The notice will include the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision. Notwithstanding the foregoing, if the Committee's meeting schedule is such that it holds regularly scheduled meetings at least quarterly, the Plan Administrator's final determination with respect to the claimant's appeal may be made within the period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii) in lieu of the 60-day period (120-day period if extended due to special circumstances) described above.

If an appeal is denied in whole or part by the Plan Administrator, written notice of the decision to deny such appeal shall be promptly furnished to the claimant within 60 days after receipt of the claim for benefits, within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the appeal, or within such extended period outlined in Department of Labor Regulations Section 2560.503-1(i)(1)(ii), as the case may be. Each notice of denial of an appeal shall be in writing and shall contain the specific reason or reasons for the denial; specific reference to the pertinent Plan provisions upon which the denial is based, and a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. Any decision by the Plan Administrator shall be final.

All communications between the Plan Administrator and the claimant or the claimant's duly authorized representative shall be in writing unless the claimant or the claimant's duly authorized representative requests otherwise and the Plan Administrator consents thereto.

7.06 **Legal Actions**. No legal action may be brought to recover from the Plan until after the claimant has exhausted all claims and appeals to the Claims Administrator and Plan Administrator. No such action may be brought after three years from the date of the Covered Person's death.

7.07 **Autopsy**. Unless legally prohibited, the Company has the right, at its own expense, to have an autopsy performed.

ARTICLE VIII
TERMINATION OF PARTICIPATION

Except as otherwise provided in this Article, an Employee shall cease to participate in the Plan on the earliest of the following dates:

(a) The date as of which the Plan is terminated;

(b) The date that the Plan is amended to terminate coverage with respect to an Employee;

(c) The date an Employee is no longer eligible for coverage under Article III, including without limitation as a result of the Employee's employer no longer being a Related Employer;

(d) The date an Employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994, except as provided under the NiSource Inc. Military Leave Policy;

(e) The date an Employee terminates employment.

ARTICLE IX
MISCELLANEOUS PROVISIONS

9.01 **Information to Be Furnished**. Employees shall provide such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

9.02 **Limitation of Rights**. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Employee any legal or equitable right against the Company or any Employer, except as provided herein.

9.03 **Plan Not Contract**. The Plan shall not be deemed to constitute a contract between the Company or any Employer and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or of any Employer or to interfere with the right of the Company or of any Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement that may be made by the Company with the bargaining representative of any Employee.

9.04 **Fiduciary Operation**. Each Plan Fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries (as those terms are defined in ERISA) and (1) for the exclusive purpose of providing benefits to participants and their

beneficiaries and defraying reasonable expenses of administering the Plan; (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (3) in accordance with the documents and instruments governing the Plan, except as otherwise required by law.

9.05 **No Guaranty**. No person shall have any right or interest in the Plan other than as specifically provided herein. Except to the extent required by law, neither the Company nor any Employer shall be liable for the payment of any benefit provided for herein; all benefits hereunder shall be payable only from the Plan, and only to the extent that the Plan has been allocated sufficient assets.

9.06 **No Limitation of Management Rights**. Participation in the Plan shall not lessen the responsibility of an Employee to perform his or her duties satisfactorily, or affect the rights of the Company or of any Employer to discipline or terminate an Employee.

9.07 **Employees' Responsibilities**. Each Employee is responsible for providing the Plan Administrator with his or her current address and his or her Beneficiary's current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Claims Administrator shall have any obligation or duty to locate an Employee. If a Beneficiary becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect, (2) the Beneficiary does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

9.08 **Right of Recovery**. Whenever the Plan, for whatever reason, has overpaid the amount of benefits that should have been provided, the Claims Administrator shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Claims Administrator shall determine: any persons to, or for, or with respect to whom, such payments were made, and/or any insurance company or other organization.

9.09 **Governing Law and Venue**. The Plan shall be governed by and construed according to ERISA, the Code, and the laws of the State of Indiana, to the extent Indiana law does not conflict with the Code and ERISA, and to the extent Indiana law is not preempted by ERISA. In order to benefit Participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 9.09 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each Participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

9.10 **Severability**. In the event any portion of the Plan is declared by a court of competent jurisdiction to be void, said portion shall be deemed severed from the remainder of the Plan, and the balance of the Plan shall remain in full force and effect.

9.11 **Participant Litigation**. In any action or proceeding involving the Plan, Employees or any other person having or claiming to have an interest in the Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof, except as required

by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Company under the Plan by or on behalf of any person, and such action results adversely to such person or, if a legal action arises because of conflicting benefit claims, the cost to the Company or other organization or institution of defending the action will be charged to the sums, if any, which were involved in the action or were payable to such person.

9.12 Counterparts. The Plan document may be executed in any number of identical counterparts, each of which shall be deemed a complete original in itself and may be introduced in evidence or used for any other purpose without the production of any other counterparts.

9.13 Notice. Any notice given under the Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Claims Administrator, when addressed to it at its office; or if given to an Employee, when addressed to the Employee at his or her address as it appears on the records of the Claims Administrator.

9.14 Extension of Plan to Related Employers.

(a) With the approval of the Plan Administrator, any Related Employer may adopt the Plan and qualify its Employees hereunder by taking such action to adopt the Plan and making such contributions to the cost of coverage as the Plan Administrator may require.

(b) The Plan will terminate with respect to any Employer that has adopted the Plan pursuant to this Section if the Employer ceases to be a Related Employer, revokes its adoption of the Plan by appropriate corporate action, permanently discontinues any required contributions for its Employees, is judicially declared bankrupt, makes a general assignment for the benefit of creditors, or is dissolved.

(c) The Committee shall have the sole right to amend or terminate the Plan and shall act as the agent for each Related Employer that adopts the Plan for all purposes of administration thereof.

ARTICLE X
FUNDING, AMENDMENT AND TERMINATION OF THE PLAN

10.01 Plan Self Insured. The Plan is a self-insured plan. All contributions made to the Plan are used to pay claims and related expenses thereunder.

10.02 Rights Unsecured. The right of a Beneficiary or any other person to receive a distribution hereunder, shall be an unsecured claim against the general assets of the Company and no Beneficiary or any other person shall have any rights in any amount allocated for his or her benefit under the terms of the Plan, or any other specific assets of the Company. All amounts allocated pursuant to the terms of the Plan shall constitute general assets of the Company and may be disposed of by the Committee at such time and for such purpose as it may deem appropriate. Benefits payable pursuant to the terms of the Plan shall be paid solely as required out of the general assets of the Company or from any other funding vehicle as may be established by the Company.

10.03 Amendment. The Committee reserves the right at any time and from time to time to change or amend, in whole or in part, any or all of the provisions of the Plan. Unless expressly provided otherwise, no amendment shall affect, or be construed to affect, any existing delegations to amend the Plan. Any such amendment may have retroactive or prospective effect. However, no change or amendment shall be made that enables any part of Plan assets to be used for, or diverted to, purposes other than the exclusive benefit of those entitled to benefits hereunder and the payment of reasonable expense of administration.

10.04 Termination. The Company is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. In their sole and absolute discretion, the Company may discontinue contributions to the Plan and the Committee may terminate the Plan, in whole or in part, at any time, in each case without liability for such discontinuance or termination.

10.05 Collective Bargaining Agreement. Notwithstanding the foregoing provisions of this Article, the right to amend or terminate the Plan shall be subject to the express terms of any applicable collective bargaining agreement.

[Remainder of page intentionally left blank.]

IN WITNESS WHEREOF, the Committee has caused this amended and restated Plan to be executed on its behalf, by one of its members duly authorized, this 22nd day of June, 2015, to be effective January 1, 2015.

NISOURCE BENEFITS COMMITTEE

By: _____

FIRST AMENDMENT TO THE NISOURCE TRAVEL ACCIDENT PLAN

(As Amended and Restated Effective January 1, 2015)

WHEREAS, NiSource Inc. (the "Company") maintains the NiSource Travel Accident Plan, as amended and restated effective January 1, 2015 (the "Plan"); and

WHEREAS, pursuant to Section 10.03 of the Plan, and subject to Section 10.05 thereof, the NiSource Benefits Committee (the "Committee") has reserved the right to amend the Plan; and

WHEREAS, pursuant to resolutions adopted by the Committee, the Committee desires to amend the Plan, effective as of June 1, 2016, to modify the definition of "Non-Represented" to clarify the status, during the period from June 1, 2016, to April 30, 2019, of specified participants in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and the Northern Indiana Public Service Company with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019.

NOW, THEREFORE, the Plan is hereby amended, effective as June 1, 2016, as follows:

1. Section 2.11, **"Non-Represented"** of the Plan is hereby amended to recite in its entirety as follows:

> **2.11 "Non-Represented"** "Non-Represented" means an Employee who is not covered by a collective bargaining agreement between an Employer and a union. Notwithstanding the foregoing, for purposes of the Plan, the term "Non-Represented" shall include an Employee employed by the Northern Indiana Public Service Company ("NIPSCO") in the role of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) (hereinafter, "Damage Prevention Coordinator") during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and NIPSCO with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019, unless such Employee was considered a NIPSCO employee covered by a collective bargaining agreement between NIPSCO and a union immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator. Effective as of May 1, 2019, Employees employed by NIPSCO in the position of Damage Prevention Coordinator shall no longer be considered Non-Represented Employees for purposes of the Plan, unless otherwise negotiated in an agreement between the bargaining unit and NIPSCO.

2. All other provisions of the Plan shall remain unchanged.

IN WITNESS WHEREOF, the Committee has caused this First Amendment to the NiSource Travel Accident Plan to be executed on its behalf by one of its members duly authorized, effective as of June 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____

One of the Members of the Committee

NiSource

Program:	**Business Development Program** **Tuition Reimbursement**
EFFECTIVE DATE:	**Separation Date (defined herein)**
APPROVED:	**Robert Campbell**

1. Purpose

The ability and the effectiveness of an employee and the value added to NiSource Inc. (the "Company") may be enhanced if the employee acquires additional, formal education in work-related disciplines where the Company has a need for improving its knowledge base, talent and/or resources. NiSource subsidiaries will reimburse eligible employees a part of the expenses incurred in obtaining such additional education, subject to its prior approval. The Company reserves the right to reject any course and/or program application. The Company also reserves the right to modify or terminate the program at any time.

2. Eligibility

Any active, full-time exempt or non-exempt employee, who has been with the Company for six months, may apply for course/program approval. If an employee terminates for any reason, or if the Company subsidiary by whom he is employed ceases to be a member of the same controlled group of corporations as the Company, within the meaning of Section 414(b) of the Internal Revenue Code of 1986, as amended, eligibility ends at time of termination or at the time the subsidiary ceases to be a member of the controlled group.

This Policy is intended to be limited in scope and, unless specifically provided by the terms of a collective bargaining agreement, bargaining unit personnel are not eligible to participate in this program. To the extent that bargaining unit personnel are eligible under a Collective Bargaining Agreement, such eligibility is limited to those courses of study identified by the Policy and approved by the employee's Vice President or General Manager. For bargaining unit personnel not specifically covered by the terms of a Collective Bargaining Agreement, participation in the education assistance program shall be at the Company's sole discretion and eligibility shall be limited to those courses of study identified by the Policy and approved by the employee's Vice President or General Manager.

3. Approved Coursework

In this Program, "course" is defined as a single subject; "program" or "curriculum" is defined as a group of courses designated by the institution as a requirement for completion.

For Exempt employees, any course, program or curriculum that is pertinent to and, in the opinion of the Company, of a type that will be of mutual benefit to Company operations, may be approved under the program for reimbursement. Approving Managers should take into consideration the employee's performance and expectations of ascending to higher levels of accountability which are clearly documented and supported by the employee's DFWs and/or the Talent Review Process.

For Non-Exempt employees, only courses/curriculum that are related to and/or may lead to a degree in engineering or a geology/sciences related field will be considered for approval at the function leader's discretion. In rare situations, if a Manager has a documented development plan that will improve an employee's ability to ascend to an exempt/supervisory position in the near future, those requests will be considered.

Pursuit of study of any subject, course or curriculum should not interfere with the employee's regular work schedule, compromise or interfere with the employee's job performance, or require the scheduling of time away from the regular work schedule for classroom attendance or class preparation. Courses with requirements that conflict with these guidelines must have Vice President approval and include alternative arrangements that ensure no interference with Company operations. To qualify under this Program, coursework must be taken at a college or university accredited by a Regional Accrediting Organization recognized by the Council for Higher Education accreditation.

Degrees/Curriculum/Courses qualifying under the Program include:

- Undergraduate Degrees
- Master Degrees
- Correspondence/Distance Learning/Online Courses
- Degree-completion courses
- Certification preparation courses (i.e., Professional Engineer, etc.)
- Non-degree work-related courses
- Pre-requisite courses
- Life Experience Assessment Programs (LEAP)
- Credit for Life Experience Programs (CLEP)

A maximum of nine credit hours or three courses per semester will be allowed, except in the case of bona fide degree-completion programs that have a modified semester plan. The Company reserves the right to reject any elective that is clearly unrelated to the employee's major area of study or that covers inappropriate subject matter.

4. Expenses Qualifying for Reimbursement / Budget Responsibility

For all employees, tuition, books, lab fees and graduation fees will be reimbursed at 70% so long as the employee completes the course with a passing grade or pass for a pass/fail course.

Reimbursement will not be made for student activity fees, parking fees, non-resident fees, tools, supplies, shipping charges, tuition financing charges, meals, mileage, or coursework for which the employee receives financial assistance from another source.

No reimbursement shall be made for expenses related to a course completed by a Spin-Off Employee if the Employee Request for Reimbursement and all required supporting documentation are submitted to the Tuition Reimbursement Coordinator on or after the Separation Date.

"Separation Date" means July 1, 2015, or if later, the date of the consummation of all transactions necessary to effectuate the CPG Spin-Off.

"CPG Spin-Off" means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of Columbia Pipeline Group, Inc.

A "Spin-Off Employee" is an employee of Columbia Pipeline Group, Inc. or its affiliates who was covered under this Program immediately prior to the Separation Date and who became ineligible for such coverage in connection with the CPG Spin-Off.

Reimbursements for eligible expenses will be capped at $5,250 per calendar year for all employees. For programs that have a majority of classes in one calendar year, but the reimbursement is requested in the next calendar year, those courses and related reimbursement will be considered (for cap related purposes only) to have occurred in the previous year when a majority of classes were scheduled.

If an employee voluntarily terminates or is terminated for cause before or after completion of the program within specified time limits, the employee will be required to reimburse the Company based on the Tuition Repayment Agreement.

Reimbursements made in relation to this program will be the responsibility of the department/function of the requesting employee and will be funded from that specific budget. In situations where two functions are involved (i.e., a non-exempt finance employee makes application to take engineering courses), the two function leaders may discuss to determine if cost sharing is appropriate.

5. Procedure for Program/Course Approval

a. Employee fills out **Tuition Reimbursement Program Application** form. A complete course curriculum outlining all degree requirements must be included with the application.
b. Employee must also fill out and sign **Tuition Repayment Agreement.**
c. Employee's manager approves application and repayment agreement (Business Unit VP/Leader also approves application only), and forwards to the designated Tuition Reimbursement Coordinator. Tuition Reimbursement Coordinator must receive applications at least fifteen (15) days prior to program start date to allow time for review.
d. Tuition Reimbursement Coordinator e-mails employee approval or denial of program.
e. Employees must re-apply for Program approval if:
    i. They elect to pursue a different area of study or courses not on the outline;
    ii. They elect to pursue previously approved Program at another institution; or
    iii. They do not pursue coursework for a period of twelve (12) months.
f. As courses are taken within a previously approved Program, employee e-mails notice of course, course number and start date to Tuition Reimbursement Coordinator at least 15 days prior to course start date.
g. Tuition Reimbursement Coordinator e-mails confirmation of course to employee.

6. Procedure for Reimbursement

a. Employee pays for course and other qualifying expenses, fills out Employee Request for Reimbursement form and submits original copy of itemized receipt to Tuition Reimbursement Coordinator. This step can be taken prior to completion of course, but reimbursement will not be made until satisfactory course completion.
b. Tuition Reimbursement Coordinator notifies Payroll Department of reimbursement amount. Reimbursement is processed corresponding with employee's next regular pay cycle as a separate line item on the pay advice. Per IRS guidelines, reimbursements are non-taxable up to $5,250 per employee year. Amounts above $5,250 will be included in taxable income.
c. Upon completion of course, employee forwards original copy of grade report or certificate of completion to Tuition Reimbursement Coordinator. Original grade reports and receipts will not be returned; therefore, employees should ensure they maintain duplicate records.

d. Subsequent reimbursements will not be made under this Program until passing grades are received to document completion of courses that were previously taken and reimbursed.
e. In order to qualify, requests for reimbursement, original grade reports and receipts must be sent to Tuition Reimbursement Coordinator within 60 days after course is completed.
f. Employees will not be paid for expenses prior to the expenses being incurred (i.e., no advances).

7. Program Administration

The **HR Delivery Team** coordinates the Tuition Reimbursement program is. The HR Delivery Team will answer questions about the Program, make available all forms necessary for participation, and process routine applications and request for reimbursement.

NISOURCE INC.

ADOPTION ASSISTANCE PLAN

As Amended and Restated Effective as of January 1, 2016

NISOURCE INC.
ADOPTION ASSISTANCE PLAN

1. How the Plan Works.

Effective January 1, 1999, Columbia Energy Group ("Columbia") established the Adoption Assistance Plan for employees of Columbia. Effective January 1, 2004, the Adoption Assistance Plan was amended and restated to broaden its coverage, and was renamed the NiSource Inc. Adoption Assistance Plan (the "Plan"). Effective January 1, 2011, the Plan was amended and restated for the purpose, among other things, of increasing the maximum amount of qualified adoption expenses that may be reimbursed by the Plan. Effective July 1, 2015, the Plan was amended and restated in connection with the CPG Spin-Off (defined below) and to reflect certain statutory, regulatory and plan design changes. This is an amended and restated version of the Plan, effective as of January 1, 2016, that reflects certain statutory, regulatory and plan design changes.

The purpose of the Plan is to offset a portion of qualified adoption expenses by providing financial assistance in the adoption of an eligible child. Subject to the terms and conditions below, NiSource Inc. (the "Company") and its Related Employers (each an "Employer") will reimburse up to $3,500 of qualified adoption expenses for each successful adoption of an eligible child. A "Related Employer" is (1) any corporation that is a member of a controlled group of corporations (as defined in Section 414(b) of the Internal Revenue Code of 1986, as amended (the "Code")) that includes the Company; (2) any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; and (3) any member of an affiliated service group (as defined in Section 414(m) of the Code) that includes the Company.

2. Eligibility.

Subject to the other terms and conditions of this Plan, an Employer will reimburse qualified adoption expenses that were paid or incurred while an individual is an Employee who is actively at work, provided the expenses are incurred in connection with an adoption of an eligible child that becomes final while the individual is an Employee. Notwithstanding the foregoing or any other provision of this Plan, with respect to a CPG Spin-Off Employee, no reimbursement of qualified adoption expenses will be made if the Adoption Reimbursement Claim Form (referred to in paragraph 5), together with all required documentation, is not submitted to the Plan on or before the Separation Date.

An "Employee" is (1) a full-time, salaried employee of an Employer, (2) a full-time, non-union, hourly employee of an Employer or (3) a full-time or part-time union employee of an Employer, if the employee's union has collectively bargained for participation in the Plan. No independent contractor shall be treated as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Committee (defined below). The following restrictions apply:

- Employees who are on a long-term disability or salary continuation status at the time the adoption is finalized are not eligible for reimbursement.

- Employees who are on a Family and Medical Leave Act and/or approved leave of absence are eligible for reimbursement of qualified adoption expenses from the Plan when they have returned to work, if the expenses meet the Plan requirements.

Except for a part-time union employee whose union has collectively bargained for participation in the Plan, part-time and temporary employees are not eligible for the Plan. Adoption benefits will be made available to new eligible Employees immediately upon hire. If an Employee and spouse are both Employees, only one Employee can utilize the benefit. Eligible children must be under age 18, except where the state in which the Employee resides has determined that the adopted child has a special need.

Participation under the Plan will end on the earliest to occur of the following: (i) the date an individual is no longer an Employee eligible to participate in the Plan, (ii) the date the Employee terminates employment with an Employer, or (iii) the date the Plan is terminated.

"CPG" means Columbia Pipeline Group, Inc., a Delaware corporation.

"CPG Spin-Off" means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG

A "CPG Spin-Off Employee" is an employee of CPG or its affiliates who was covered under this Plan immediately prior to the Separation Date and who became ineligible for such coverage in connection with the CPG Spin-Off.

"Separation Date" means July 1, 2015.

3. Financial Reimbursement.

Qualified adoption expenses are reimbursable up to a maximum of $3,500 per child; provided, however, that qualified adoption expenses paid or incurred prior to January 1, 2011 shall be reimbursed up to a maximum of only $2,500 per child. Qualified adoption expenses include the following, provided that the expenses are paid or incurred by the Employee and are directly related to and have as their principal purpose, the legal adoption by the Employee of an eligible child, are not incurred in violation of state of federal law or in carrying out any surrogate parenting arrangement, are not for the adoption of the child of the Employee's spouse and are not reimbursed by another source:

- Agency and placement fees

- Medical expenses of birthmother (directly related to the adoption)

- Medical expenses of the eligible child (directly related to the adoption)

- Legal fees and court costs

- Required travel/lodging expenses
- Required temporary foster care
- Immigration, immunization and translation fees

An eligible child is an individual who has not attained age 18 or who is physically or mentally incapable of caring for himself.

Qualified adoption expenses shall determined in accordance with Code Section 137 and any rules, regulations or other guidance issued by the Internal Revenue Service thereunder or under Code Section 23, including without limitation the instructions to Internal Revenue Service Form 8839, Qualified Adoption Expenses.

4. Adoption Expense Reimbursement for a Spouse's Child.

Notwithstanding the preceding paragraph, the Employer will reimburse the actual expenses, up to a maximum of $3,500, for the uncontested adoption by an Employee of a spouse's child or children. Amounts so reimbursed are not qualified adoption expenses for purposes of the Code exclusion from income provisions or the adoption tax credit. Consequently, amounts reimbursed under this paragraph are includable in the gross income of the Employee and are subject to federal and state income tax withholding, FUTA, FICA, and unemployment taxes. An Employee who plans to request reimbursement from the Plan for such expenses should consult with a tax advisor before submitting expenses to the Employer for reimbursement.

5. Procedure for Reimbursement.

Reimbursement of adoption expenses can begin as soon as the adoption is finalized. Employees must submit a legal adoption agreement along with the Adoption Reimbursement Claim Form to the address indicated on the Claim Form to begin the reimbursement process. All expenses for an adoption should be submitted together, and itemized receipts substantiating the amount and nature of the expenses incurred need to be attached for documentation. Employees shall furnish the plan administrator with any other evidence, data or information the plan administrator considers necessary or desirable to administer the Plan. The Adoption Reimbursement Claim Form is available through MySource for Human Resources at 1-888-640-3320. To be considered for reimbursement, all expenses must be submitted no later than twelve months after the adoption becomes final.

6. Family and Medical Leave Act (FMLA).

The Employer recognizes that the adoption process may require time off from work. Employees who adopt may apply for leave under the Family and Medical Leave Act for up to 12 weeks. Employees are requested to provide their manager with as much preliminary information on need for time off as possible. This will prevent unplanned interruptions in the work unit while allowing the Employee to take necessary leave time.

7. Coordination with Other Benefits.

The Employer will not reimburse an Employee for adoption expenses that have been paid through another plan (*e.g.*, Employee and spouse's medical plan, health care spending accounts, or a spouse's employer adoption assistance plan).

8. Taxation of Reimbursements.

The $3,500 maximum reimbursement for adoption assistance to an Employee under paragraph 3 is excludable from the Employee's gross income if his or her family's modified adjusted gross income ("MAGI") does not exceed $201,920 (effective January 1, 2016 and as adjusted thereafter for inflation). If the Employee family's MAGI is between $201,921 and $241,919 (effective January 1, 2016 and as adjusted thereafter for inflation), part of the reimbursement will be treated as taxable income to the Employee. If the Employee family's MAGI is $241,920 or more (effective January 1, 2016 and as adjusted thereafter for inflation), all of the reimbursement will be treated as taxable income to the Employee. State taxes may also apply to reimbursements made under the Plan.

The Employer will not withhold income taxes on payments for qualified adoption expenses under the Plan. The Employer will withhold FICA and FUTA taxes from these amounts. If all or part of the reimbursement is taxable to the Employee, it must be included in his or her gross income with applicable withholding for income, FICA and FUTA tax purposes. An Employee's withholding may not be enough to cover the tax on those payments; therefore, it is the Employee's responsibility to give the Employer a new form W-4 to adjust withholding, or to make estimated tax payments, to avoid a penalty for underpayment of estimated tax.

9. Additional Considerations.

In addition to the tax exclusion of reimbursements under the Plan described in paragraph 8, the Code allows families with MAGI of $201,920 or less (effective January 1, 2016 and as adjusted thereafter for inflation) to take a tax credit for qualified adoption expenses of up to $13,460 (effective January 1, 2016 and as adjusted thereafter for inflation). If the Employee family's MAGI is between $201,921 and $241,919 (effective January 1, 2016 and as adjusted thereafter for inflation), the Employee may take a partial credit. If the Employee family's MAGI is $241,920 or more (effective January 1, 2016 and as adjusted thereafter for inflation), the Employee may not take the credit.

An Employee could receive both the tax exclusion of reimbursements under the Plan and the tax credit under the Code, as long as the reimbursement and the tax credit cover different expenses.

If a child with special needs is adopted, the Code allows families, subject to the income limits, to take the maximum tax credit even if they have no qualified adoption expenses. A "child with special needs" means any child if (i) a State has determined that the child cannot or should not be returned to the home of his or her parents, (ii) such State has determined that there exists with respect to the child a specific factor or condition (such as his or her ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that

such child cannot be placed with adoptive parents without providing adoption assistance, and (iii) such child is a citizen or resident of the United States (as defined in Code Section 217(h)(3)).

For many Employees, it may be most advantageous to take as large a tax credit as allowed by the Code before receiving a Plan reimbursement from the Employer. If an Employee expects to use both the tax credit and the Plan reimbursement, he or she will want to carefully plan the amount of reimbursement requested under the Plan because (except for expenses related to the adoption of a special needs child) an Employee cannot take the tax credit for any expenses for which he or she received a reimbursement under the Plan. An Employee is responsible for understanding the tax treatment of reimbursements under this Plan and of the tax credit provided under the Code, and for claiming the applicable income exclusion by filing Form 8839 with his or her federal income taxes. Accordingly, an Employee should consult his or her own tax advisor in connection with these tax issues. Neither the Company, nor any Employer, nor the Committee is responsible for, or makes any guarantee concerning, the tax consequences of reimbursements made under the Plan or of an Employee's decision to obtain reimbursement under the Plan or to seek a tax credit under the Code.

10. Nondiscrimination.

The Plan is intended not to discriminate in favor of certain highly compensated employees as defined in Code Section 414(q). If, in the judgment of the plan administrator, the operation of the Plan in any plan year would result in such prohibited discrimination, then the plan administrator shall, in its full discretion, select and exclude from eligibility and/or coverage under the Plan such Employees as shall be necessary to assure that, in the judgment of the plan administrator, the Plan does not discriminate.

11. Administration of the Plan.

The NiSource Benefits Committee (the "Committee") administers the Plan and has sole discretionary authority to interpret the Plan, to make eligibility and benefit determinations, and to make factual determinations in connection with the Plan. Any determinations of the Committee are final and binding.

12. Governing Law and Venue.

The Plan shall be governed by and construed according to the Code, and the laws of the State of Indiana (without regard to the conflicts of law principles thereof), to the extent Indiana law does not conflict with the Code, and to the extent Indiana law is not preempted by the Code. In order to benefit participants under this Plan by establishing a uniform application of law with respect to the administration of the Plan, the provisions of this Section 12 shall apply. Any suit, action or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Plan shall be brought in any court of the State of Indiana or in the United States District Court for the Northern District of Indiana. The Company, each Employer, each participant, and any related parties irrevocably and unconditionally consent to the exclusive jurisdiction of such courts in any such litigation related to this Plan and any transactions contemplated hereby. Such parties irrevocably and unconditionally waive any objection that venue is improper or that such litigation has been brought in an inconvenient forum.

13. Amendment or Termination.

The Committee reserves the right to amend the Plan at any time for any purpose. The Committee further reserves the right to terminate the Plan at any time, in whole or in part, for any reason.

[Signature page follows]

IN WITNESS WHEREOF, this amendment and restatement of the Plan is hereby executed on this 17th day of December, 2015, by the duly authorized officer of the Company, to be effective as of January 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: _____
One of its Members

FIRST AMENDMENT TO THE NISOURCE INC. ADOPTION ASSISTANCE PLAN

(As Amended and Restated Effective January 1, 2016)

WHEREAS, NiSource Inc. (the "Company") maintains the NiSource Inc. Adoption Assistance Plan, as amended and restated effective January 1, 2016 (the "Plan"); and

WHEREAS, pursuant to Section 13 of the Plan, the NiSource Benefits Committee (the "Committee") has reserved the right to amend the Plan; and

WHEREAS, pursuant to resolutions adopted by the Committee, the Committee desires to amend the Plan, effective as of June 1, 2016, to modify the eligibility provisions to clarify the status, during the period from June 1, 2016, to April 30, 2019, of specified participants in the designated union position of Damage Prevention Coordinator with an assigned job code of NP3459, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and the Northern Indiana Public Service Company with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019.

NOW, THEREFORE, the Plan is hereby amended, effective as June 1, 2016, as follows:

1. Section 2, "**Eligibility**" of the Plan is hereby amended to recite in its entirety as follows:

2. Eligibility.

Subject to the other terms and conditions of this Plan, an Employer will reimburse qualified adoption expenses that were paid or incurred while an individual is an Employee who is actively at work, provided the expenses are incurred in connection with an adoption of an eligible child that becomes final while the individual is an Employee. Notwithstanding the foregoing or any other provision of this Plan, with respect to a CPG Spin-Off Employee, no reimbursement of qualified adoption expenses will be made if the Adoption Reimbursement Claim Form (referred to in paragraph 5), together with all required documentation, is not submitted to the Plan on or before the Separation Date.

An "Employee" is (1) a full-time, salaried employee of an Employer, (2) a full-time, non-union, hourly employee of an Employer or (3) a full-time or part-time union employee of an Employer, if the employee's union has collectively bargained for participation in the Plan. No independent contractor shall be treated as an Employee during the period he or she renders service as an independent contractor. Any person retroactively or in any other way found to be a common law employee will not be eligible under the Plan for any period during which he or she was not treated as an Employee by the Committee (defined below). The following restrictions apply:

- Employees who are on a long-term disability or salary continuation status at the time the adoption is finalized are not eligible for reimbursement.

- Employees who are on a Family and Medical Leave Act and/or approved leave of absence are eligible for reimbursement of qualified adoption

expenses from the Plan when they have returned to work, if the expenses meet the Plan requirements.

Except for a part-time union employee whose union has collectively bargained for participation in the Plan, part-time and temporary employees are not eligible for the Plan. Adoption benefits will be made available to new eligible Employees immediately upon hire. If an Employee and spouse are both Employees, only one Employee can utilize the benefit. Eligible children must be under age 18, except where the state in which the Employee resides has determined that the adopted child has a special need.

For purposes of the Plan, the term "full-time, non-union, hourly employee of an Employer" shall include an employee employed by the Northern Indiana Public Service Company ("NIPSCO") in the role of Damage Prevention Coordinator with an assigned job code of NP3459 (or subsequent job title and/or code that becomes applicable for this specific position, as recognized by the Plan Administrator) (hereinafter, "Damage Prevention Coordinator") during the period from June 1, 2016 to April 30, 2019, as negotiated in the Memorandum of Understanding ("MOU"), generally effective June 1, 2016, resulting from collective bargaining between the United Steelworkers of America, Local 12775, AFL-CIO-CLC, and NIPSCO with respect to such position for the period specified in the MOU from June 1, 2016 to April 30, 2019, unless such employee was considered an employee covered by a collective bargaining agreement between NIPSCO and a union immediately prior to June 1, 2016, or if later, immediately prior to becoming employed in the position of Damage Prevention Coordinator. Effective as of May 1, 2019, Employees employed by NIPSCO in the position of Damage Prevention Coordinator shall no longer be considered full-time, non-union, hourly employees of an Employer for purposes of the Plan.

Participation under the Plan will end on the earliest to occur of the following: (i) the date an individual is no longer an Employee eligible to participate in the Plan, (ii) the date the Employee terminates employment with an Employer, or (iii) the date the Plan is terminated.

"CPG" means Columbia Pipeline Group, Inc., a Delaware corporation.

"CPG Spin-Off" means the transaction pursuant to which there was distributed to holders of shares of common stock of the Company, on a pro rata basis, all of the outstanding shares of common stock of CPG

A "CPG Spin-Off Employee" is an employee of CPG or its affiliates who was covered under this Plan immediately prior to the Separation Date and who became ineligible for such coverage in connection with the CPG Spin-Off.

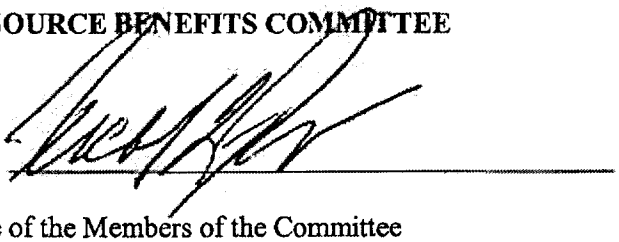
"Separation Date" means July 1, 2015.

2. All other provisions of the Plan shall remain unchanged.

[Signature page follows]

IN WITNESS WHEREOF, the Committee has caused this First Amendment to the NiSource Inc. Adoption Assistance Plan to be executed on its behalf by one of its members duly authorized, effective as of June 1, 2016.

NISOURCE BENEFITS COMMITTEE

By: 

One of the Members of the Committee